**Macomb County Community Mental Health**

**Request to Refer to an Intensive SRS Setting**

Person Served:      MCCMH Case Number:

Date of Request:

Person’s Current Location:

How long have they been at the current location:

Has the person served been given a discharge notice from another SRS setting? [ ] Yes [ ] No

If yes, provide specific details regarding the reason for the discharge:

If they are in a hospital, are they ready for discharge? [ ] Yes [ ] No

If not ready for discharge, provide specific details as to their status:

Identify the intensive SRS residential setting that is being requested:

Provide the clinical rationale as to why this setting is required to meet the person’s treatment needs:

Describe all actions previously taken to secure a residential placement and the outcomes of those actions:

Requestor’s Name:

Provider Agency Name:

Email:

Phone Number:

**Submit this form to PlacementReviewCommittee@mccmh.net**

**Administrative Section**

Enhanced Setting appropriate? [ ] Yes [ ] No

Rationale for determination:

Outcome of referral to the Enhanced SRS Provider:

Placement date:       Residential Provider: