



Interagency PNO Client Transfer Form
(for Title XIX/XXI and HB Children Only)

To the Clinical Director/Single Point of Contact of: (Agency Name) _____ FAX: _____

Please accept this fax as notification that on (date) _____, the following consumer was referred to your agency for on-going care and transfer of the clinical responsibilities for the following reason: _____

Consumer Full Name: _____ DOB: _____ CIS ID #: _____

Discharge/Transfer Note

Consumer is currently on medications: [] Yes - Number of days of medication remaining _____ [] No
Consumer needs psychiatric evaluation: [] Yes [] No
Outpatient Counseling: [] Yes [] No If yes frequency: _____
Child and Family Team Established: [] Yes [] No
Medical Management appointment scheduled: [] Yes [] No
Consumer is currently: [] Title 19 [] Title 21 [] HB funded
Treatment Start Date: _____ Treatment End Date: _____
Consumer receives Court-Ordered Treatment: [] Yes [] No
Other Comments: _____

Attached Documentation

[] Face Sheet (include all important contact names and phone numbers)
[] Intake & Treatment/Service Plan [] Crisis Safety Plan
[] Progress Notes/CFT Notes [] Strength & Culture Discovery
COT Petition MH #: _____ Effective Date: _____ Expiration Date: _____
[] Medical Documents (Psychiatric evaluation, psychiatric progress notes, medication administration records)
[] Release of Information Form (signed by parent/guardian if under 18)

Provider Utilization Data

Number of hours and/or amount of funds expended: _____
Flex Funds for current Calendar Year (not to exceed \$1525) _____
Respite Services for current Fiscal Year (not to exceed 30 days or 720 hours) _____
Special Needs: [] Yes [] No Please Explain: _____

Transferring Clinical Director/Single Point of Contact

Name: _____ Phone: _____

Signature: _____ Date: _____

CONFIDENTIALITY NOTICE

WARNING: Unauthorized interception of this telephonic communication could be a violation of Federal and State law. This information has been disclosed to you from records that may be protected by federal confidentiality rules (42 CFR, Part 2) and may be protected by state laws regarding confidentiality of patient records. These rules prohibit you from making further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. The document accompanying this telecopy transmission may contain confidential information which is legally privileged; the information is intended only for the use of the recipient named above. You are hereby notified that any disclosure, copying, distribution or action taken in reliance of the contents of this telecopied information is STRICTLY PROHIBITED. If you have received this telecopy in error, please immediately notify sender by telephone at the number above to arrange for the return of the original documents.

Effective date: 07/01/18