



**Interagency PNO Client Transfer Form**  
*(for title XIX/XXI and HB Children Only)*  
Form 3.17.1

To the Clinical Director/Single Point of Contact of: (Agency Name) \_\_\_\_\_ Fax Number: \_\_\_\_\_

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**

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