1915(i) RISE Referral Submission Form

Submit all referral information by the following means:

Encrypted Email	1915iRISEInitiative@ky.gov (Email submissions **must be encrypted** to protect confidential information.)
Fax Number	502-564-8917 (A fax cover sheet clearly labeled "CONFIDENTIAL INFORMATION" is required.)
Phone	502-564-9189

Enter all referral contact information below:

Referral Name	
Referral Organization	
Referral Phone Number	
Referral Email Address	

1915(i) RISE Application - Complete all Applicant Information

(Title)	Choose One	Gender	Choose One
First Name		Last Name	
Middle Name		Suffix	
Birth Date		Goes By	
Soc. Sec. #		Medicaid Number	
Email		Phone Number	

Race (check all that apply):

☐ American Indian / Alaskan Native
☐ Asian
☐ Asian Indian
☐ Black / African American
☐ Chinese
☐ Declined
☐ Filipino
☐ Guamanian or Chamorro
☐ Japanese
☐ Korean
☐ Multiracial
☐ Native Hawaiian / Other Pacific Islander
☐ North African / Middle Eastern
☐ Samoan
☐ Undetermined
☐ Unknown
☐ Vietnamese
☐ White
☐ Other:

Ethnicity / Hispanic Origin – Check all that apply:

☐ Bengali	☐ Indian	☐ Newar	☐ Tamang
☐ Central American	☐ Magar	☐ Not Hispanic or Latino	☐ Tamil
☐ Chakma	☐ Malays	☐ Other Spanish Origin	☐ Tharu
☐ Chinese	☐ Marma	☐ Puerto Rican	☐ Unable to Determine
☐ Cuban	☐ Mexican	☐ Sinhalese	
☐ Hispanic	☐ Moor	☐ South American	

Tribe (if applicable)	
Class Membership (if applicable)	

Residential Address

If in the care of a residential agency or individual, list the name and affiliation below:

Street 1	**Street 2**

City	**State**	**ZIP**	**Country**
			USA

Primary Phone	**Secondary Phone**	**Additional Phone**

Mailing Address ☐ **Check if Same as Residential Address Above**

If in the care of a residential agency or individual, list the name and affiliation below:

Street 1	**Street 2**

City	**State**	**ZIP**	**Country**
			USA

Primary Phone	**Secondary Phone**	**Additional Phone**

Required Supporting Documentation

(These items must be submitted with the application. The application cannot proceed until all required items highlighted are received.)

Required Documents:

These items must be included with referral or application.

- KY Determination Criteria Checklist for Serious Mental Illness (https://dbhdid.ky.gov/documents/cmhc/crd/ChecklistSMI.pdf)
- Statement of Serious Mental Illness diagnosis from a Licensed Behavioral Health Professional
- Psychiatric hospital discharge records from the past two years
- Psychosocial history

Additional Supporting Documentation (Optional but Helpful)

These items are not required, but strongly recommended to support the

assessment:

- Current medication list

Revised 1/2026