

Submit all referral by one the following means:

- Call 502-564-9189 to complete a referral by phone.
- Complete this form and send by fax or encrypted email:
 - Fax: 502-564-8917 (must include cover sheet labeled “Confidential Information”)
 - Email: 1915iRISEInitiative@ky.gov (must be encrypted)

Required documents must be submitted with the referral. If submitting records that are several pages or more, please label/highlight the relevant information being requested below (SMI diagnosis, SUD diagnosis if present, discharge records and notes, licensed behavioral health professional, etc.)

- KY Determination Criteria Checklist for Serious Mental Illness – completed and signed by a licensed behavioral health professional. This checklist can be found here: <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 (if applicable)
- Psychosocial assessment and history

For the Referral Source - Complete all Information Below:	
Who is referring?	<input type="checkbox"/> Self <input type="checkbox"/> Other – fill out Name, Organization, Phone, and Email below:
Referral Name	
Referral Organization	
Referral Phone Number(s)	
Referral Email Address	
Select one of the following three options:	
<input type="checkbox"/>	Individual being referred is their own legal decision-maker
<input type="checkbox"/>	Power of Attorney is in effect – attach court-order documentation
<input type="checkbox"/>	The individual has a legal guardian or conservator – attach court-order documents and letter of guardianship dated within the past 12 months; complete information below:
Guardian/Conservator Name	
Relationship to Individual	
Phone Number(s)	
Email Address	

Complete all Applicant Information on pages 2 through 4:

(Title)	Choose One	Gender	Choose One
First Name		Last Name	
Middle Name		Suffix	
Birth Date		Goes By	
Soc. Sec. #		Medicaid Number	
Email		Phone Number	
<u>Race (check all that apply):</u> <input type="checkbox"/> American Indian / Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Asian Indian <input type="checkbox"/> Black / African American <input type="checkbox"/> Chinese <input type="checkbox"/> Declined <input type="checkbox"/> Filipino <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Multiracial <input type="checkbox"/> Native Hawaiian / Other Pacific Islander <input type="checkbox"/> North African / Middle Eastern <input type="checkbox"/> Samoan <input type="checkbox"/> Undetermined <input type="checkbox"/> Unknown <input type="checkbox"/> Vietnamese <input type="checkbox"/> White <input type="checkbox"/> Other:		<u>Ethnicity / Hispanic Origin – Check all that apply:</u> <input type="checkbox"/> Bengali <input type="checkbox"/> Central American <input type="checkbox"/> Chakma <input type="checkbox"/> Chinese <input type="checkbox"/> Cuban <input type="checkbox"/> Hispanic <input type="checkbox"/> Indian <input type="checkbox"/> Magar <input type="checkbox"/> Malays <input type="checkbox"/> Marma <input type="checkbox"/> Mexican <input type="checkbox"/> Moor <input type="checkbox"/> Newar <input type="checkbox"/> Not Hispanic / Latino <input type="checkbox"/> Other Spanish Origin <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Sinhalese <input type="checkbox"/> South American <input type="checkbox"/> Tamang <input type="checkbox"/> Tamil <input type="checkbox"/> Tharu <input type="checkbox"/> Unable to Determine	
Tribe (if applicable)			
Class Membership (if applicable)			

Homeless Risk Factors are present – check if the individual meets any of the criteria below:

- Currently Homeless.
- At risk of homelessness (per [24 CFR § 578.3](#)).
- History of frequent (i.e., more than one per year) stays in inpatient settings.
- Experienced homelessness in the past 24 months or formerly homeless; now residing in U.S. Department of Housing and Urban Development assisted housing.

Personal Care Home – check if the individual lives in a Personal Care Home.

Residential Address - If in the care of a residential agency or individual, list the name and affiliation below. If not, leave blank:

In the care of:			
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. If not, leave blank:

In the care of:			
Street 1		Street 2	
City	State	ZIP	Country
			USA
Primary Phone	Secondary Phone		Additional Phone

What is your Preferred Region to receive services? Enter County or Counties below:

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Medication List (If available) – please include a list of all current medications and information in the chart below; if additional room is needed, include as a separate attached document

Name	Dose (#)	Unit (mg, etc.)	Route (oral, injection, etc.)	Frequency (2x daily, etc.)	As Needed? <input type="checkbox"/> Y <input type="checkbox"/> N
					<input type="checkbox"/> Y <input type="checkbox"/> N
					<input type="checkbox"/> Y <input type="checkbox"/> N
					<input type="checkbox"/> Y <input type="checkbox"/> N
					<input type="checkbox"/> Y <input type="checkbox"/> N

					<input type="checkbox"/> Y <input type="checkbox"/> N
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					<input type="checkbox"/> Y <input type="checkbox"/> N
					<input type="checkbox"/> Y <input type="checkbox"/> N
					<input type="checkbox"/> Y <input type="checkbox"/> N

Consent to 1915(i) RISE and Signature

By signing below, I give consent for the individual listed on this application to be referred to the 1915(i) RISE Initiative. I also acknowledge that the 1915(i) RISE Initiative has been explained to the individual listed on this referral application. Additionally, the individual understands that participation is voluntary and of their own choice.

BEFORE SIGNING: Please ensure that all required documents from page 1 are included.

Signature of individual or guardian			
Printed name of signature		Date of signature	
Relationship of individual signing document	<input type="checkbox"/> Self <input type="checkbox"/> Guardian <input type="checkbox"/> Conservator <input type="checkbox"/> Other – specify below		
Other Information			

<u>Accommodation Requests:</u> Please let us know individual needs or preferences. We will do our best to accommodate requests.	
Language	<input type="checkbox"/> American Sign Language (ASL) Interpreter <input type="checkbox"/> Other Language (please specify):
Support Personnel	<input type="checkbox"/> No <input type="checkbox"/> Yes If yes, who will attend?
Other Requests	