**4.1.1 Inter-Agency Transfer & Transition Checklist**

Cenpatico developed this checklist to aid you in ensuring that all necessary documentation has been forwarded to the receiving agency during an Inter-agency transfer or transition due to agency closure. In the event an audit of transfers or transition plans occurs, these items will be reviewed to ensure compliance with the requirements outlined in the Cenpatico Edition of the Provider Manual Section 3.17. This checklist must be filed in the medical record once it has been completed. Please ensure this form is fully completed and legible.

Member Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sending Agency:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Receiving Agency:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

|  |  |  |  |
| --- | --- | --- | --- |
| **Required Action Checklist Item Documented in Member Chart** | **Sending Agency: Y/N** | **Receiving Agency: Verified Y/N** | **Action To Be Taken, Date & Responsible Party if Checklist Item Not Completed** |
| The transfer was discussed with and agreed upon with the member/guardian AND the agreement was documented. *Note date.* |  |  |  |
| A transfer CFT/ART was completed |  |  |  |
| The Member/Guardian was present at the transfer CFT/ART |  |  |  |
| The SBAR was completed during the transfer CFT/ART |  |  |  |
| Peer and ancillary agencies attended the transfer CFT/ART |  |  |  |
| The transfer CFT/ART note is accessible in the Receiving Agency Record |  |  |  |
| The transfer was entered into the Portal by the Sending Agency within 2 days following the transfer CFT/ART |  |  |  |
| The transfer was accepted/rejected in the Portal by the Receiving Agency within 5 days of notification |  |  |  |

**Inter-Agency Transfer & Transition Checklist (Continued)**

Member Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sending Agency:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Receiving Agency:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

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| **Documentation Checklist Item** | **Sending Agency: Document Present Y/N/NA** | **Receiving Agency: Verified Y/N/NA** | **Action To Be Taken, Date & Responsible Party if Document Not Present (including NA)** |
| Release of Information for Receiving Agency |  |  |  |
| Intake Assessment AND Last Two Assessments |  |  |  |
| Financial Intake Information *(i.e. birth certificate, AHCCCS ID, Social Security Card, Proof of residency)* |  |  |  |
| SMI Determination, PM form 3.10.1 *(if applicable)* |  |  |  |
| T36 COT documentation *(if applicable)* |  |  |  |
| Proof of Special Assistance, PM form 5.4.1 *(if applicable)* |  |  |  |
| 2 Most Recent Service Plans/Recovery Planners/Peer Driven Service Plans |  |  |  |
| Medication List |  |  |  |
| Recent Lab Work |  |  |  |
| PCP Name/Contact Information |  |  |  |
| Medical Notes *(if applicable)* |  |  |  |
| Most Recent Demographic |  |  |  |
| Most recent CFT/ART note |  |  |  |
| 3 months of Progress Notes including Psychiatric & RN notes |  |  |  |
| Psychiatric Evaluation *(if applicable)* |  |  |  |
| Most Recent Screening Tools *(i.e. ASAM,DRC Screening, if applicable)* |  |  |  |
| Most Recent Crisis Plans/Advance Directives/Wrap Plans *(if applicable)* |  |  |  |
| Flex Fund Documentation *(if applicable)* |  |  |  |
| **For Children**, include most recent CASII |  |  |  |
| **For High Needs Children**, include the SNCD |  |  |  |

**SBAR Hand-off Form**

Member Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sending Agency:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Receiving Agency:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

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| --- | --- | --- | --- |
| **Situation** |  | | |
| DOB: |  | CIS ID: |  |
| Phone #: |  | BH Category: |  |
| Address: |  | | |
| Diagnosis Axis I: |  | Axis II: |  |
| Diagnosis Axis III: |  | Axis IV: |  |
| Diagnosis Axis V: |  | Funding Source: |  |
| Guardian/OHR Rep Name & Phone# *(if applicable):* |  | GSA: |  |
| Sending Agency Contact Person |  | Contact Phone #: |  |
| Receiving Agency Contact Person: |  | Contact Phone #: |  |
| Reason for hand-off: |  | | |
| **Background** |  | | |
| What precipitated the member transferring? |  | | |
| PCP Name: |  | | |
| PCP Contact Information: |  | | |
| Pertinent Medical History: |  | | |
| Chronic Medical Conditions: |  | | |
| Hospitalizations (psychiatric/medical): |  | | |
| **Assessment** |  | | |
| Psychosocial Status: |  | | |
| Natural Supports & Contact Info: |  | | |
| Ancillary Agency Supports (Peer/Family Agencies) & Contact Info: |  | | |
| All Current Medications (Including OTC): |  | | |
| Pharmacy Name, Location & Phone #: |  | | |
| Most Recent Laboratory Results: |  | | |

**SBAR Hand-off Form (Continued)**

|  |  |
| --- | --- |
| **Recommendations** |  |
| Immediate Needs: |  |
| Short Term Goals: |  |
| Services Recommended: |  |
| Services Recommended in Addition to Those Listed on Previous Service Plan: |  |
| Receiving Agency Contact Date: |  |
| Responsible Party for Contact: |  |
| Medication Appointment (if applicable): |  |

**Sending Agency Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Receiving Agency Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Member gives permission for follow up call & message regarding the transfer?** (Y/N) \_\_\_\_\_\_\_\_\_\_\_\_\_\_