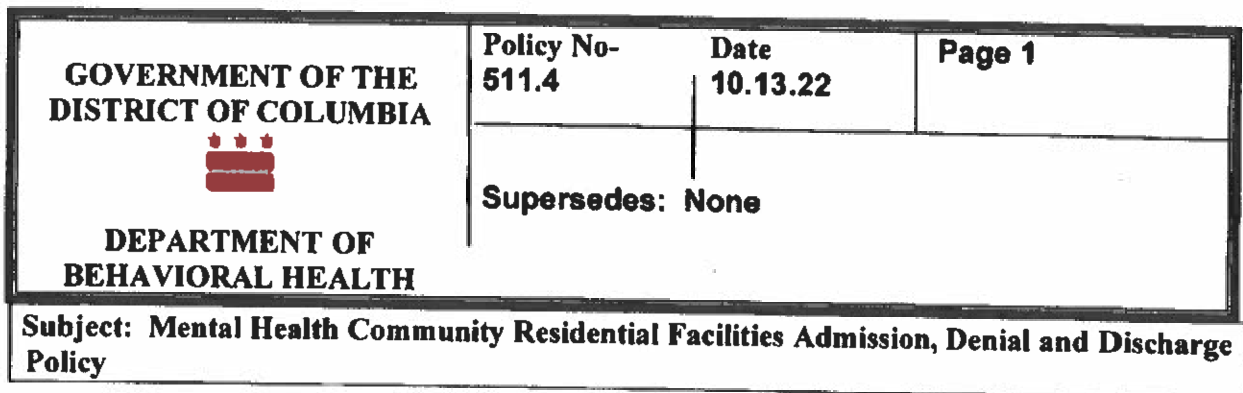


GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF BEHAVIORAL HEALTH	Policy No- 511.4	Date 10.13.22	Page 1
	Supersedes: None		

Subject: Mental Health Community Residential Facilities Admission, Denial and Discharge Policy

1. **Purpose**. To establish a process that complies with governing Federal and District laws and regulations for Department of Behavioral Health (DBH or the Department) licensed Mental Health Community Residence Facilities (MHCRF) operators to admit residents, deny resident admissions, and to discharge/transfer/relocate residents. This policy shall also serve as the Department's model discharge plan.

2. **Applicability**. DBH-licensed MHCRF operators with a Human Care Agreement; all DBH-certified Core Services Agencies (CSA) and Assertive Community Treatment (ACT) Teams.

3. **Authority**. Americans with Disabilities Act, 42 U.S.C. Ch. 126 §§ 12101 *et seq*. (ADA); Nursing Home and Community Residence Facilities Protections Act D.C., Code §§ 44-1003.01 *et seq.*; District of Columbia Human Rights Act, D.C. Code §§ 2-1401.01 *et seq.* (Human Rights Act); Title 22-A District of Columbia Municipal Regulations (DCMR) Chapter 3; Title 22- A DCMR Chapter 34; Title 22-A DCMR Chapter 38.

4. **Background**. Obtaining and maintaining a safe and secure home is a critical component of mental health recovery. Housing provides the requisite stability to achieve treatment goals, which reduces the likelihood that people with mental health illnesses will cycle in and out of homelessness, jails, shelters and hospitals. Recognizing the important role that housing plays in recovery, the Department has established a network of housing providers and supports, including ninety-three (93) MHCRFs throughout the District. Through the provision of safe and appropriately supervised housing, meals and assistance with daily living, MHCRFs serve an integral role in supporting hundreds of DBH consumers living successfully in the least restrictive community-based settings.

The Department has enacted regulations to clarify resident and MHCRF operator rights and responsibilities through the MHCRF admission, denial and discharge processes. *See* Title 22-A DCMR Chapter 38. Recently, DBH received several MHCRF denial and discharge notices that did not comport with governing laws, regulations or policies, and which necessitated Director-ordered placements for residents following denials and fair hearings at the Office of Administrative Hearings in response to invalid discharges. This policy is intended to establish a procedure for MHCRFs and CSA/ACT Teams to ensure that all MHCRF admissions, denials and discharges meet statutory and regulatory requirements.

5. **Definitions.**

5a. Assertive Community Treatment (ACT) Team: A mobile, inter-disciplinary team of qualified practitioners and other staff certified under Title 22-A DCMR Chapter 34 to deliver ACT services to DBH consumers in accordance with Title 22-A DCMR Chapter 34 and governing policies.

5b. Core Services Agency (CSA): A provider certified by DBH to deliver community-based Mental Health Rehabilitation Services (MHRS) pursuant to Title 22-A DCMR Chapter 34 that has entered into a Human Care Agreement with the Department to provide specified MHRS.

5c. Discharge: Termination of a resident's stay at or relocation from an MHCRF due to action taken by the MHCRF operator or the Mayor, or by the choice of the resident. There are three (3) types of discharge: Voluntary Discharge, Emergency Discharge, and Involuntary Discharge.

(1) Voluntary Discharge: Termination of a resident's stay in an MHCRF by the choice of the resident.

(2) Involuntary Discharge: Termination of a resident's stay in an MHCRF due to action taken by the MHCRF operator.

(3) Emergency Discharge: Termination of a resident's stay in an MHCRF made pursuant to D.C. Code §§ 44-1003.02 or 44-1003.05 *et seq.*

5d. Emergency: An adverse event that may compromise a resident's health, safety, and/or welfare.

5e. Mental Health Community Residence Facility (MHCRF): A publicly or privately owned community residence facility that provides twenty-four (24) hour supervised care and a home-like environment in a house or apartment building for individuals age eighteen (18) or older:

(1) With a principal diagnosis of mental illness;

(2) Who require twenty-four (24) hour on-site staff supervision, monitoring, personal assistance with activities of daily living, lodging, and meals; and

(3) Who are not in the physical custody of the Department of Corrections.

5f. Relocation: The movement of a resident from one room of the MHCRF where they reside to another, whether voluntary or involuntary, pursuant to the Nursing Home and Community Residence Facility Residents' Protection Act.

5g. Representative: Any person who:

(1) Is knowledgeable about the resident and has been assigned by the resident to represent them;

(2) Has been appointed by a court to administer a resident's financial or personal affairs, or to advocate for the resident's rights; or

(3) The District of Columbia Long Term Care Ombudsman (LTCO) or their designee, if no person has been appointed.

5h. Resident: Any person, who is not a staff member, who resides in an MHCRF under the auspices of Title 22-A DCMR Chapter 38.

5i. Transfer: The movement of a resident from one MHCRF to another MHCRF operated by the same provider, whether voluntary or involuntary.

6. **Policy.**

6a. All DBH-licensed MHCRF operators and DBH-certified CSA/ACT Teams shall adhere to the policy as set forth below.

6b. This policy has been developed in consultation with the MHCRF operators and the LTCO and shall serve as the District's model discharge plan pursuant to the requirements of the Nursing Home and Community Residence Facility Residents' Protections Act of 1985, (D.C. Official Code §§ 44-1001.01 *et seq.*; § 44-1003.10) to ensure the safe and orderly transfer, discharge and relocation of MHCRF residents, and to protect the residents' health, safety, welfare and rights.

7. **Procedure.**

7a. MHCRF Application

(1) To begin the MHCRF application process, the potential resident's CSA/ACT Team shall send an application packet electronically to the DBH Department of Residential Services, Supports and Continuity of Services (RSS) at crfcert@dc.gov. All MHCRF applications must include:

(a) Level of Care Form for MHCRF Placement;

(b) MHCRF Medical Clearance Form;

(c) Demographic Form;

(d) Clinical Summary Form;

(e) Official Income Verification, including proof of income (i.e., SSI, SSDI, VA, retirement benefits, annuities, etc.) dated within ninety (90) calendar days of the MHCRF referral indicating that the resident has sufficient funds to pay rent. If the potential resident receives representative payee services through the DBH-contracted representative payee vendor, Income Verification on agency letterhead signed by the administrator of the Finance/Benefits Unit is acceptable. If income is not in place, the resident must provide proof of an application for benefits (i.e. SSI, SSDI, VA) or the status of other sources of income (i.e. retirement, annuities, etc.);

(f) Authorization for Disclosure signed by consumer or guardian; and

(g) A copy of the MHCRF applicant's Department-approved functional assessment report.

(2) The CSA/ACT Team housing liaison shall review all MHCRF application packets for sufficiency before they forward the application to RSS for review. RSS shall notify the housing liaison within three (3) business days of any information that is missing from the application packet.

(3) RSS shall review all applications upon receipt and place incomplete applications in a 'Pending' status until the CSA/ACT Team provides all outstanding documents needed to complete the application package.

(4) Upon receipt of a completed MHCRF application, RSS will provide the housing liaison:

(a) A Level of Care Certificate (LOCC);

(b) An MHCRF Vacancy List; and

(c) An Optional State Payment (OSP) Application.

(5) The CSA/ACT staff member who placed the individual in the CRF shall complete and submit the completed OSP Application to the Department of Health Care Finance (DHCF) at osp@dc.gov within two (2) business days of the resident's placement in an MHCRF. If awarded, OSP offsets a portion of the resident's MHCRF rent. DBH may pay locally-funded PUSH funds to MHCRF operators while a resident's OSP application is pending, and indefinitely if a MHCRF resident is not a U.S. citizen or does not otherwise qualify for OSP.

(6) The LOCC shall be effective for ninety (90) calendar days from date of issuance. The potential resident's CSA/ACT Team may send a "Request for Extension of the LOCC Date" no less than two (2) weeks prior to the LOCC expiration date, if required. The request must include a narrative indicating the status of the applicant, reason(s) for the extension request, a current List of Prescribed Medical and Psychiatric Medications, and an updated Psychiatric Evaluation. Only one (1) extension request may be accepted. If the potential resident is not placed in an MHCRF before the LOCC expires, the potential resident's CSA/ACT Team must submit a new MHCRF Application Packet to RSS for a new LOCC.

(7) A resident's CSA/ACT team shall provide RSS with an updated level of care package on a yearly basis and upon any change in circumstances. RSS shall evaluate each LOCC package pursuant to Section 7a of this policy upon receipt and issue an updated LOCC, if appropriate.

(8) The potential resident/guardian or their CSA/ACT Team may request reconsideration of the LOCC by providing additional information to RSS at crf.cert@dc.gov. RSS shall respond to requests for LOCC reconsideration within seven (7) business days following receipt of the request. A potential resident may grieve a LOCC certificate pursuant to the procedure established in Title 22-A DCMR Chapter 3.

7b. MHCRF Admissions

(1) All DBH-licensed MHCRFs shall admit potential residents with a principal diagnosis of mental illness if: (1) the MHCRF meets the potential resident's DBH-approved level of care; and (2) the MHCRF can safely and adequately provide care to the potential resident. Except in unusual circumstances particular to an individual applicant or residence, any licensed MHCRF should safely and adequately provide care to the potential resident meeting the MHCRF's level of licensure.

(2) As part of the matching process, the MHCRF shall receive an MHCRF packet from the Department and/or the potential resident's CSA/ACT Team.

(3) All potential residents have the option to tour and/or interview with MHCRF staff to support the potential resident's decision about whether to move to the home if accepted. A Department-licensed MHCRF shall not deny or delay admission based solely on a potential resident's inability or decision not to engage in the MHCRF interview process.

(4) The MHCRF should review the potential resident's MHCRF packet to:

(a) Determine whether the MHCRF meets the potential resident's level of care;

(b) Whether the MHCRF can safely and adequately provide care; and

(c) To understand the potential resident's needs to facilitate admission if the potential resident selects the MHCRF as their home.

(5) An MHCRF may deny admission to a potential resident when:

(a) The MHCRF is not the appropriate level of care for the potential resident; or

(b) The MHCRF cannot safely and adequately provide care to the potential resident.

(6) All Department-licensed MHCRFs must comply with the ADA and the Human Rights Act when admitting potential residents. Specifically, no Department-licensed MHCRF shall deny admission based upon a potential resident's:

(a) Age;

(b) Gender;

(c) Race;

(d) Physical or mental disability;

(e) HIV status;

(f) Religion;

(g) Sexual orientation;

OCT 1 3 2022

(h) Gender identity or expression;

(i) National origin;

(j) Marital status;

(k) Source of payment for the service;

(l) Need for assistance with medication administration;

(m) Active substance use issues, history of substance use or participation in a substance use treatment program;

(n) Need for limited or intermittent nursing care;

(o) The potential resident's desire to not attend a day program outside of the MHCRF; or

(p) The agency from which the potential resident receives CSA or ACT services.

7c. MHCRF Denials

(1) When an MHCRF denies admission to a potential resident, it must provide written reasons for the denial on the Department-approved form (*See* Exhibit 9) within three (3) business days to the Director, the potential resident, and their treatment team.

(2) The Director may order the potential resident's admission to the MHCRF over the MHCRF's denial if the admission is consistent with the Department-approved level of care, the MHCRF is licensed to provide the approved level of care, and the MHCRF has a vacant bed. An operator's failure to accept a Director-ordered placement may result in DBH taking adverse action against the MHCRF's license and/or Human Care Agreement.

7d. MHCRF Discharges/Transfers/Relocations

(1) Immediately upon learning that an MHCRF resident is experiencing an issue that could escalate to the issuance of an emergency or involuntary discharge/transfer/relocation notice, the MHCRF operator must take action to try to resolve the concern and avert the potential discharge/transfer/relocation (*e.g.*, contact DBH to address issues with OSP, call a care plan meeting with the resident's treatment team to discuss behavioral concerns, etc.).

(2) An MHCRF shall not discharge, transfer, or relocate a resident without first notifying the Department (the Director of Residential Services and Supports). The MHCRF must also promptly notify the following parties of the resident's discharge/transfer/relocation:

(a) LTCO;

(b) The resident's CSA/ACT Team; and

(c) The resident's physician when the resident's physical or mental condition changes and the resident requires services or supports that necessitate the discharge/transfer/relocation.

(3) The MHCRF must provide the resident and their representative oral and written notice of a proposed discharge or transfer at least twenty-one (21) calendar days in advance of the discharge or transfer, and at least seven (7) calendar days in advance of a relocation within the MHCRF. Immediately upon becoming aware of a proposed discharge/transfer/relocation, the MHCRF must engage the resident's CSA/ACT Team to begin the discharge planning process and to provide supports to the resident, including a discharge plan that includes the address for an appropriate new placement for the resident. *See* Section 7h.

7e. <u>MHCRF Voluntary Discharge/Transfer/Relocation</u>

(1) A voluntary discharge/transfer/relocation must be **resident-initiated**. The steps to issue a voluntary discharge/transfer/relocation notice are as follows:

(a) All voluntary discharges/transfers/relocations must be initiated by a resident informing an operator of their intent to move from or within the MHCRF.

(b) Following this notification, the MHCRF operator must notify the following parties and hold a voluntary discharge/transfer/relocation notice conference to discuss the potential discharge/transfer/relocation as soon as all of the following parties are able to be present:

(1) The MHCRF operator;

(2) The resident/guardian (if applicable);

(3) The resident's CSA/ACT Team;

(4) The DBH Licensure Division;

(5) The DBH Division of Care Access and Innovation; and

(6) Representative of the LTCO.[1]

(c) At a minimum, the parties at the conference must:

(1) Clarify the circumstances that led to the proposed

[1] The MHCRF resident, at their sole discretion and without coercion from any party, may leave the MHCRF before the parties convene the voluntary discharge notice conference. The MHCRF resident may invite other parties to the voluntary discharge notice conference provided that the resident signs a valid Release of Information permitting any person who is not a member of the Resident's treatment team to participate in the meeting. (*See* Exhibit 4, DBH HIPAA Form 3).

discharge/transfer/relocation and the reasons for the proposed move;

(2) Confirm that the resident initiated the discharge/transfer/relocation;

(3) Confirm that the resident was not coerced to submit the voluntary discharge/transfer/relocation notice;

(4) Verify the resident's new address, if available;

(5) Identify activities and responsibilities for coordination of any post-discharge care and/or support;

(6) Identify activities and responsibilities for coordination of the resident's new housing placement;

(7) Respond to any questions the resident/guardian may have about the discharge; and

(8) Reach consensus regarding the type of discharge/transfer/relocation notice – voluntary or involuntary – to be submitted.

(d) The voluntary discharge/transfer/relocation notice conference may be held in person or via teleconference or videoconference.

(e) After the voluntary discharge/transfer/relocation notice conference, the MHCRF must complete the MHCRF Discharge/Transfer/Relocation Meeting Form and submit it to DBH along with the appropriate discharge notice, as indicated below. *See* Exhibit 3, MHCRF Discharge/Transfer/Relocation Meeting Form.

(f) If DBH determines that the discharge/transfer/relocation was initiated by the resident without coercion, the operator must submit a Voluntary Discharge/Transfer/Relocation Notice that has been completed by the resident to DBH and the LTCO. *See* Exhibit 2, Mental Health Community Residence Facility Voluntary Discharge Notice.

(g) If DBH determines that the discharge/transfer/relocation was initiated by a party other than the resident, or the resident was coerced into requesting a voluntary discharge/transfer/relocation, the operator must submit a valid Involuntary Discharge/Transfer/Relocation Notice to DBH and the LTCO. *See* Exhibit 1, Mental Health Community Residence Facility Involuntary Discharge/Transfer/Relocation Notice.

(2) DBH will review all notices submitted and approve notices that meet the requirements of Title 22-A DCMR Chapter 38 and the Nursing Home and Community Residence Facilities Protections Act (D.C. Code §§ 44-1003.01 *et seq.*).

7f. <u>MHCRF Involuntary Discharge/Transfer/Relocation</u>

(1) The **MHCRF operator** must initiate an involuntary discharge/transfer/relocation. The basis upon which an operator may issue an involuntary discharge include situations where the discharge:

(a) Is essential to meet the resident's documented health-care needs or DBH-issued level of care;

(b) Is essential to safeguard the resident, other residents, staff, or neighbors of the MHCRF from physical or emotional injury;

(c) The resident, guardian or payee has not paid MHCRF rent, after the MHCRF has provided the resident reasonable and appropriate notice;

(d) The discharge is necessary to meet the MHCRF's reasonable administrative needs and there are no other practicable alternatives available; or

(e) The MHCRF is closing or reducing licensing capacity.

(2) At least ten (10) days before issuing an Involuntary Discharge/Transfer/Relocation Notice, the MHCRF operator must hold an involuntary discharge/transfer/relocation notice conference to discuss the potential discharge/transfer/relocation. The following parties must, to the extent possible and with outreach and absences documented, be present:

(a) The MHCRF operator;

(b) The resident/guardian (if applicable);

(c) The resident's CSA/ACT Team;

(d) A representative of the DBH Licensure Division;

(e) A representative of the Division of Care Access and Innovation; and

(f) A representative of the LTCO.

(3) At a minimum, the parties at the conference must[2]:

(a) Clarify the circumstances that led to the proposed discharge and the reasons for the proposed move;

(b) Identify activities and responsibilities for coordination of the any post-discharge care and/or support;

---

[2] The MHCRF resident may choose to invite other parties to the involuntary discharge notice conference. The Resident must provide verbal authorization or sign a valid Release of Information permitting any Party who is not a member of the Resident's treatment team to participate in the meeting. *See* Exhibit 4, DBH HIPAA Form 3.

(c) Identify activities and responsibilities for coordination of any of the resident's new housing;

(d) Verify the resident's new address, if available; and

(e) Respond to any questions the resident/guardian may have about the discharge/transfer/relocation.

(4) The involuntary discharge/transfer/relocation notice conference may be held in person or via teleconference or videoconference.

(5) After the involuntary discharge/transfer/relocation notice conference, the MHCRF shall complete the MHCRF Discharge/Transfer/Relocation Conference Form and submit it to DBH along with the Involuntary Discharge/Transfer/Relocation Notice. *See* Exhibit 3, MHCRF Discharge Conference Form; Exhibit 1, MHCRF Involuntary Discharge/Transfer/Relocation Notice.

(6) DBH shall review all notices submitted and approve notices that meet the requirements of Title 22-A DCMR Chapter 38 and the Nursing Home and Community Residence Facilities Protections Act (D.C. Code §§ 44-1003.01 *et seq.*).

7g. MHCRF Emergency Discharge/Transfer/Relocation

(1) **DBH** may order an emergency discharge/transfer/relocation of MHCRF residents for one or more of the following reasons:

(a) The MHCRF is unlawfully operating pursuant to its license or without a valid license;

(b) The MHCRF's license has been suspended, revoked, or DBH has refused to renew the license;

(c) The MHCRF is closing and has not made adequate arrangements for the relocation of MHCRF residents at least thirty (30) days before the anticipated closure;

(d) The MHCRF requests DBH assistance with the transfer or discharge of a resident, and the resident and guardian (if applicable) consents; or

(e) An emergency exists which poses an immediate danger of death or serious physical injury to the resident.

(2) In the instance of an emergency discharge caused by a threat of danger of death or serious physical injury to a resident, the operator must immediately address the imminent threat to the resident's safety (*i.e.*, contact the police, fire department, ambulance, Crisis Response Team, etc.). Once the MHRF operator has completed all immediate emergency notifications, they must submit a written request for an emergency discharge/transfer/relocation by emailing the assigned DBH Licensure Specialist. At a minimum, the written request must include:

(a) The name, date of birth, CSA/ACT team and guardian (if any) of the person for whom the discharge/transfer/relocation is sought;

(b) The address at which the emergency discharge/relocation/transfer is sought; and

(c) The reason that the emergency discharge/transfer/relocation is sought.

(3) In all instances warranting an emergency discharge due to a threat of danger of death or serious physical injury to a resident, the MHCRF operator must complete and submit a Major Unusual Incident Report pursuant to DBH 480.1A, Reporting a Major Unusual Incident Report.

(4) DBH shall review all requests for emergency discharge/transfer/relocation to determine whether they meet the requirements of D.C. Code §§ 44-1003.01 *et seq.* The Licensure Division shall notify the MHCRF operator and the resident's CSA/ACT Team immediately once DBH determines whether to order an emergency discharge/transfer/relocation.

(a) If DBH orders an emergency discharge/transfer/relocation because: (1) the MHCRF is operating without current valid license or in violation of restrictions placed on its license; (2) the MHCRF intends to close and adequate arrangements have not been made at least thirty (30) calendar days before the anticipated closure date; or (3) the MHCRF requests DBH's assistance with a discharge/transfer/relocation and the resident and their representative consent:

(1) The DBH Licensure Division shall provide the resident, their representative and the LTCO a written notice stating the reasons for the emergency discharge and the right to contest it; and

(2) DBH will hold an informal conference with the resident, their representative and the LTCO in-person, via teleconference or videoconference before the emergency discharge/transfer/relocation. Any party may present objections to the proposed emergency discharge/transfer/relocation or discharge plan during the informal conference.

(b) If DBH orders an emergency discharge because it has determined that an emergency exists which poses an immediate danger of death or serious physical injury to the resident, DBH shall notify the MHCRF and the resident that an emergency has been found to exist and a removal is ordered. Whenever practicable, DBH shall involve the resident in discharge planning. Following the emergency discharge/transfer/relocation, DBH shall provide the MHCRF, the resident and their representative written notice stating the basis for the action and advising them of their appeal rights.

(c) Within ten (10) calendar days of an emergency transfer/discharge/relocation, a resident may appeal the action by submitting a written hearing request to the Department.

7h. Discharge/Transfer/Relocation Planning

(1) Discharge/transfer/relocation planning must include the resident, their representative, the current MHCRF, CSA/ACT Team, and DBH working collaboratively to ensure continuity of care for the resident after the resident moves from a MHCRF.

(2) The MHCRF, resident/representative, the CSA/ACT Team and DBH must begin discharge/transfer/relocation planning immediately when resident's move is confirmed.

(3) Discharge/transfer/relocation planning must include the following:

(a) Resident and resident representative involvement in the discharge planning process including:

(1) The MHCRF and the CSA/ACT Team must discuss with the resident and their representative the reasons for the discharge/transfer/relocation in a manner the resident and their representative understand. The MHCRF and/or CSA/ACT Team must provide the resident and their representative an opportunity to ask questions;

(2) Person-centered discharge/transfer/relocation planning, including engaging the resident and their representative to determine the resident's needs and preferences about the proposed discharge/transfer/relocation;

(3) Discussions with the resident and their representative about potential new placements; and

(4) Ensuring that the resident's belongings, excess funds, medical equipment, records and medication are available to be transferred to the resident's new placement, or to the resident/representative (if the new placement is not an MHCRF).

(b) The MHCRF shall remain engaged in the discharge/transfer/relocation planning process. At a minimum, the MHCRF must:

(1) Participate in all required meetings to provide insight about the resident, and their current functioning/needs to facilitate the discharge/transfer/relocation;

(2) Complete the designated sections of the Person-Centered Discharge Planning Form. *See* Exhibit 8, Person-Centered Discharge Planning Form;

(3) Assist the resident's CSA/ACT Team by supporting and preparing the resident for the move, including preparing the resident's medication, medical equipment (if any), records, belongings, personal funds allowance and vital documents to be timely, neatly and securely transferred to the new placement;

(4) Before the resident moves, the MHCRF must provide the resident and their representative with a copy of the resident's record of all funds that the MHCRF has handled or managed for the resident including personal funds and excess rent money. The MHCRF shall direct any remaining funds to the resident's CSA/ACT Team.

(c) The CSA/ACT Team must provide support and assistance throughout the discharge/transfer/relocation planning process including:

(1) Completing the applicable sections of the Person-Centered Discharge Planning Form. *See* Exhibit 8, Person-Centered Discharge Planning Form. The CSA/ACT Team must ensure that the Person-Centered Discharge Planning Form is completed entirely, and provide a complete and finalized copy to the resident's new placement;

(2) If the resident is applying for a new MHCRF placement, completing the resident's MHCRF packet, ensuring approval by DBH, and sharing with the resident and their representative;

(3) Convening, coordinating and leading discharge/transfer/relocation meetings with the resident/representative, members of the DBH Licensure Division, and members of the DBH Division of Care Access and Innovation.

1. During the meeting, the parties shall formalize the Written Discharge/Transfer/Relocation Plan, as described in Section 7h(4) of this policy. The resident's CSA/ACT Team shall draft the Written Discharge/Transfer/Relocation Plan and provide a copy to the resident and their representative, DBH and the resident's new MHCRF (if applicable) before the resident moves from the MHCRF.

2. In accordance with Section 7a of this policy, the CSA/ACT Team must assist the resident in applying for appropriate housing placements that meet the resident's current level of care. If the resident is applying for a new MHCRF placement, the resident's CSA/ACT Team in conjunction with the resident's MHCRF must ensure that the Resident has a current assessment (prepared within ninety (90) days of discharge), medical certification, individual Plan of Care and doctor's orders, reviewed and shared with the resident and their representative as early as possible to ensure an appropriate placement.

3. With the resident's/representative's consent, the CSA/ACT Team shall arrange visits and/or interviews at any potential placement that meets the resident's level of care.

4. For moves within the boundaries of the District of Columbia, the CSA/ACT Team shall assist the resident in transporting their belongings, medication and records to their new housing placement.

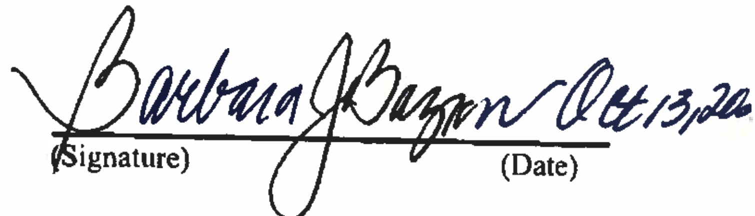
Exhibit 1, Mental Health Community Residence Facility Involuntary Notice of Discharge/Transfer from this Facility or Relocation within this Facility
Exhibit 2, Mental Health Community Residence Facility (MHCRF) Voluntary Discharge Form (Must Be Completed by the MHCRF Resident or Designee)
Exhibit 3, Mental Health Community Residential Facility (MHCRF/CRF) Conference Form
Exhibit 4, DBH HIPAA Form 3
Exhibit 5, Comparison of On-Site Visit for Use by Resident/Representative
Exhibit 6, Resident/Representative Belongings Packing Checklist
Exhibit 7, Recommendations to Support Residents during the Moving Process
Exhibit 8, Person-Centered Discharge Planning Form
Exhibit 9, MHCRF Applicant Denial Form

10. **Related Policies and Regulations.**

Title 22-A DCMR Chapter 3, Consumer Grievance Procedure
Title 22-A DCMR Chapter 38, Mental Health Community Residential Facilities Provider Certification Standards
DBH Policy 480.1A, Reporting Major Unusual Incident and an Unusual Incident

Approved By:

Barbara J. Bazron, Ph.D.
Director, DBH



(Signature) (Date)

OCT 1 3 2022

Exhibit 1

MENTAL HEALTH COMMUNITY RESIDENCE FACILITY INVOLUNTARY NOTICE OF DISCHARGE/TRANSFER FROM THIS FACILITY OR RELOCATION WITHIN THIS FACILITY

Facility Name: ______________________________
Facility Address: ______________________________
Facility E-Mail Address: ______________________________
Resident's Name: ______________________________
Resident's Phone Number: ______________________________
Resident's E-Mail Address: ______________________________
Resident's Representative's Name: ______________________________
Resident's Representative's Phone Number: ______________________________
Resident's Representative's E-Mail Address: ______________________________

This Mental Health Community Residence Facility (MHCRF) must notify you of its intent to discharge or transfer you at least twenty-one (21) calendar days before the discharge or transfer, or at least seven (7) calendar days before moving you within the MHCRF.[1]

This proposed action is a (a) Discharge/Transfer____ or (b) Relocation____.

The specific reasons for your proposed move, transfer or discharge are as follows:

____
____
____
____
____
____
____
____
____

[1] *See* Nursing Home and Community Residence Facility Resident Protection Act of 1985, D.C. Code § 44-1003.02.

OCT 1 3 2022

Exhibit 1

You are scheduled to relocate within or leave this facility on/by ____________________.
(Date)

You will be relocated to ________________ or discharged/transferred to the following
(Room Number)
location: ____.
(Address)

You should call __________________________ at ___________________ for assistance.
(CSA/ACT Team) (Phone Number)

_____________________________________ will supervise your discharge or
(Provider Representative)

transfer and provide counseling and assistance for the move.

Provider's Signature: ________________________________ Date: _________________

I, ___________________________________, acknowledge that I received this Notice of
(Resident Name)

Discharge/Transfer on _____________________________.
(Date)

___________________________________ explained this Notice to me on
(Provider's Name)
___________________________________, including my appeal rights.
(Date)

Signature of Resident: _____________________________________ Date: ___________

Signature of Resident's Representative: _______________________ Date: ___________

OCT 1 3 2022

Exhibit 1

YOUR APPEAL RIGHTS

You have a right to challenge this facility's decision to discharge, transfer, or relocate you. If the decision is to discharge you from the facility or to transfer you to another facility and you think you should not have to leave, you or your representative have seven (7) calendar days from the day you receive this notice to inform the Administrator (Residence Director, if a Community Residence Facility) or a member of the staff that you are requesting a hearing and to complete the enclosed hearing request form and mail it in the pre-addressed envelope provided. If you are mailing the hearing request form from the facility, the day you place it in the facility's outgoing mail or give it to a member of the staff for mailing shall be considered the date of mailing for purposes of the time limit. 'In all other cases, the postmark date shall be considered the **date of mailing."** If, instead, the decision is to relocate you within the facility and you think you should not have to move to another room, you or your representative have only five (5) calendar days to do the above.

If you or your representative request a hearing, it will be held no later than five (5) calendar days after the request is received in the mail; and in the absence of an emergency or other compelling circumstances, you will not be moved before a hearing decision is rendered. If the decision is to proceed with the move, in the absence of an emergency or other compelling circumstances, you will have at least five (5) calendar days to prepare for your move if you are being discharged or transferred to another facility, and at least three (3) calendar days to prepare for your move if you are being relocated to another room within the facility.

To help you in your move, you will be offered counseling services by the staff, assistance by the District Government if you are being discharged or transferred from the facility, and at your request, additional support from the Office of the D.C. Long-Term Care Ombudsman. If you have any questions about this notice or the appeal process, please do not hesitate to call the telephone number listed below for assistance:

Office of the D.C. Long-Term Care Ombudsman
Legal Counsel for the Elderly
601 E Street, NW, Building B-2nd Floor
Washington, DC 20049
(202) 434-2190 phone

OCT 1 3 2022

Other Legal Services Resources:

Neighborhood Legal Services Program
64 NY Ave, NE, Suite 180
Washington, DC 20001
(202) 832-6577
www.NLSP.org

Vida Senior Center
1842 Calvert St. NW
Washington, DC 20009
(202) 483-5800

Centro Catolico Hispano
1618 Monroe Street, NW
Washington, DC 20010
(202) 939-2400

District of Columbia Bar
Lawyer Referral and Information Service
901 4th St., NW
Washington, DC 20001
(202) 737-4700

OCT 1 3 2022
Exhibit 1

HEARING REQUEST FORM FOR RESIDENT/REPRESENTATIVE

Clerk of the Court
Office of Administrative Hearings
441 4th Street, NW
Suite 450 North
Washington, DC 20002
Phone: (202) 442-9094/ (202) 442-3789
Fax: (202) 673-3516
Via Email: oah.filing@dc.gov

cc:
Department of Behavioral Health
Accountability Administration
64 New York Ave. NE Ste. 300
Washington, DC 20002
Via Email: Leasa.Robertson@dc.gov

Dear Clerk of the Court:

This is to request a hearing under D.C. Law 6-108, Title III, to challenge the involuntary ( ) discharge, ( )transfer or ( )relocation that ( ) occurred or ( )will occur on

____.

The move is being contested based on the following:

____
____
____
____
____
____
____
____

A copy of the notice from the facility is enclosed.

Name of Resident: ______________________________________

Sincerely,

____
Resident/Representative (Print)

____
Resident/Representative (Signature)
Telephone Number: ________________

Date: ______________________

OCT 1 3 2022

Exhibit 1

Enclosure

IF YOU DISAGREE WITH OUR DECISION THAT YOU MUST MOVE AND DESIRE TO CHALLENGE IT, YOU MUST REQUEST A HEARING WITHIN SEVEN (7) DAYS FROM THE DATE YOU RECEIVE THIS NOTICE.

FOR A COMPLETE EXPLANATION OF YOUR RIGHT TO CHALLENGE OUR DECISION TO MOVE YOU, YOU SHOULD READ THE ENCLOSED FORM. FOR ASSISTANCE, YOU SHOULD CONTACT THE FOLLOWING:

Department of Behavioral Health
64 New York Avenue, NE Ste. 300
Washington, DC 20002
Via email: Leasa.Robertson@dc.gov

Office of the D.C. Long Term Care Ombudsman
601 E Street NW
Washington, DC 20049
(202) 434-2190 phone
(202) 434-6595 Fax
Via email:dcombuds@aarp.org

Office of Administrative Hearings
Attn: Clerk of the Court
441 4th Street, NW
Washington, DC 20001
(202) 442-9094 Phone
(202) 442-4789 Fax
Via email: oah.filing@dc.gov

TO MAKE YOUR HEARING REQUEST, SEND A COPY OF THE ENCLOSED FORM TO OFFICE OF ADMINISTRATVE HEARINGS, DIVISION OF LICENSURE AT DBH, AND the OFFICE OF THE D.C. LONG-TERM CARE OMBUDSMAN AT THE ADDRESSES LISTED ABOVE.

OCT 1 3 2022
Exhibit 2

MENTAL HEALTH COMMUNITY RESIDENCE FACILITY (MHCRF) VOLUNTARY DISCHARGE FORM (Must Be Completed by the MHCRF Resident or Designee)

Resident's Name: ______________________________

Resident's Phone Number: ______________________________

Resident's E-Mail Address: ______________________________

Resident's Representative's Name: ______________________________

Resident's Representative's Phone Number: ______________________________

Resident's Representative's E-Mail Address: ______________________________

MHCRF Name: ______________________________

MHCRF Address: ______________________________

MHCRF E-Mail Address: ______________________________

****

On ______________________________, I will be:
(Date)

- ☐ Moving from the MHCRF to: ______________________________.
  (Location Name (if applicable) and Address)

- ☐ Transferring to a new MHCRF: ______________________________.
  (Location Name and Address)

- ☐ Relocating within the MHCRF to: ______________________________.
  (Room Number)

OCT 1 3 2022

Exhibit 2

The specific reasons for my move, transfer, or relocation are:

____

____

____

____

____

****

Your MHCRF Operator must schedule a case conference with your CSA or ACT Team, representatives from the Department of Behavioral Health and the Long Term Care Ombudsman Program, and your guardian (if applicable) after you submit this Voluntary Discharge Form.

If you have any questions, please contact ____.

****

_________________________________ _________________________

(Signature of Resident) (Date)

_________________________________ _________________________

(Signature of Resident's Representative) (Date)

****

If an individual other than the Resident completed the Voluntary Discharge Form, please complete the following:

_________________________________ _________________________

(Name of Person Who Completed the Form) (Relationship to Resident)

_________________________________ _________________________

(Email Address) (Phone Number)

Reason that the Resident did not complete the form:

____

____

____

____

____

Exhibit 2

A copy of this form must be forwarded by the MHCRF to:

DBH, Office of Accountability Division of Licensure
64 New York Ave, NE, Third Floor
Washington, DC 20002
Fax: (202) 673-2190

Office of the D.C. Long-Term Care Ombudsman
601 E Street, NW
Washington, DC 20049
Fax: (202) 434-6595
Via email: *dcombuds@aarp.org*

****

The DBH Licensure Division:

☐ Approves this voluntary discharge; or

☐ Does not approve this voluntary discharge.

Signature of the DBH Director of Licensure: ______________________________

Date:____________________________________

OCT 1 3 2022

Exhibit 3

Mental Health Community Residential Facility (MHCRF) Conference Form

Date: ______________________ **Time:** __________ **AM/PM**

Resident Name: ______________________ **iCAMS ID:** __________

MHCRF Address: ______________________________________

MHCRF Level: ☐IR ☐SRR ☐SR

MHCRF Operator: ______________________________________

Attending	Attendee Designation	Name
☐	Resident	
☐	Representative	
☐	MHCRF Representative	
☐	CSA/ACT	
☐	Resident's Guardian (if applicable)	
☐	DBH Licensure	
☐	DBH Residential Support Services (RSS)	
☐	D.C. Long-Term Care Ombudsman (LTCO)	
☐	Interested Party 1	
☐	Interested Party 2	
☐	Interested Party 3	

Pre-Meeting Discharge Type: ☐ **Voluntary** ☐ **Involuntary** ☐ **Emergency**

Discharge Initiated By: ☐ **Resident** ☐ **MHCRF Operator**

Post-Meeting Discharge Type: ☐ **Voluntary** ☐ **Involuntary** ☐ **Emergency**

Resident Next Location:
☐ **MHCRF Transfer** ☐ **IR** ☐ **SRR** ☐ **SR** ☐ **Nursing Facility**
☐ **Psychiatric Hospital** ☐ **Family/Friend** ☐ **SRO** ☐ **Apartment**
☐ **Outside of District** ☐ **Other:** ______________________

OCT 1 3 2022

Exhibit 3

Address of Resident Next Location: ______________________________

OCT 1 3 2022

Exhibit 4, DBH HIPAA Form 3

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF BEHAVIORAL HEALTH

Authorization to Use or Disclose Protected Health Information
(including mental health information and alcohol/drug treatment and prevention information)

Name of Consumer/Client (print)	**Identification Number**
Address	**Date of Birth**
City/State/Zip Code	**Other Name(s) Used**

RELEASE INFORMATION TO:	**INFORMATION TO BE RELEASED BY:**
Name/Title: ____________	Name/Title: ____________
Organization: ____________	Organization: ____________
Address: ____________	Address: ____________
Phone #: ________ Fax # ________	Phone # ________ Fax # ________

INFORMATION TO BE DISCLOSED: **I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange) of my clinical records. This includes specific permission to release all records and other information regarding my treatment, hospitalization, and outpatient care including:** *(The following items must be checked in order to be released)*

- ☐ Drug abuse, alcoholism or other substance abuse;
- ☐ Records which may indicate the presence of a communicable or non-communicable disease, and tests for records of HIV/AIDS.

Limitations for Release:

- ☐ Only for dates of service from ____________ to ____________
- ☐ Exclusions (must list if there are any exclusions) ____________
- ☐ Only the following: (must list specific documents if applicable) ____________

INFORMATION TO BE USED FOR THE FOLLOWING PURPOSE(S) ***(List):*** ____________

EXPIRATION: This authorization will expire in three hundred and sixty-five (365) days from the date this form was signed unless one of the following is checked, in which case it will expire on the earliest date:

- ☐ On ____________ (cannot be more than three hundred and sixty-five (365) days from the date of this form).
- ☐ On ____________ *(Date Required)* when: ____________ *(Identify Specific Event)* occurs.

RIGHT TO REVOKE: I understand that I may revoke this authorization at any time by giving written notice to the organization that was authorized to release this information. I understand that revocation of this authorization will *not* affect any action by the organization that was authorized to release this information before it received my written notice of revocation. I understand that my right to revoke this authorization may be limited if the purpose of this authorization involves applying for health or life insurance.

OCT 1 3 2022

OTHER RIGHTS: I understand that this information cannot legally be redisclosed by the person or organization that received it without my authorization, except as allowed by law. I understand that I have the right to inspect my record of protected health information. I also understand that I cannot be denied enrollment or services if I decide not to sign this form. However, I may not be able to apply for benefits or renewal of benefits that would help pay for these services.

SIGNATURE OF CONSUMER/CLIENT OR PERSONAL REPRESENTATIVE:

I, ______________________________, understand that, by signing this form, I am authorizing the use and/or disclosure of the protected health information identified above.

Full Name (Print) ______________________________

Signature ______________________________ Date ______________

AUTHORITY TO ACT ON BEHALF OF CONSUMER/CLIENT (check one):

Self ________ Parent ________ *Personal Representative ________ (includes legal guardian and power of attorney)
Other ________ (must specify): ______________________________

Address: ______________________________ Phone # ______________

**Supporting documentation required for a personal representative. Attach copy to this form.*

SIGNATURE OF MINOR: If the consumer/client is at least fourteen (14) years old, but under eighteen (18) years old, this authorization is not valid unless the consumer/client signs in addition to the parent, legal guardian or other personal representative. A minor of any age may authorize disclosure based on his or her signature alone, if (1) he or she is an emancipated minor, or (2) he or she is receiving treatment or services without a parent or legal guardian giving consent.

Full Name (Print) ______________________ DOB __________ Phone # ______________

Address: ______________________________

Signature of Minor ______________________________ Date ______________

VERIFICATION OF IDENTITY OF CONSUMER/CLIENT OR PERSONAL REPRESENTATIVE PROVIDING CONSENT IS REQUIRED

- ☐ Personal identification (government issued photo ID): Attach a copy.
- ☐ Government official or Department of Behavioral Health provider's oral representation.

____

____

State what you were told and why your reliance on it was reasonable under the circumstances.

If form is mailed in, the signature on the form must be notarized or the person who is providing consent must have his or her signature notarized or attach a copy of his or her government issued ID.

I Verified the Identity of the Person Providing Consent

Full Name (Print) ______________________ Title ______________________

Signature ______________________ Date ______________________

I Revoke this Authorization Effective: ________ (Date) **Signature** ______________________ *(Consumer/Client, or personal representative and his or her relationship to the consumer/client)*

TO THE RECORDS CUSTODIAN:

1. Provide a copy of this authorization to the consumer/client or personal representative.
2. Put signed original in the consumer's clinical record.
3. Log this authorization or forward to the Privacy Officer or designee for logging.
4. Send a copy of this form with the information to be disclosed.

OCT 1 3 2022

COMPARISON OF ON-SITE VISITS FOR USE BY RESIDENT/REPRESENTATIVE

This form is meant for you to record information about each of the MHCRFs that you visit to help you make an informed decision about your new placement. To best use this form, bring it with you to each MHCRF that you visit and record your thoughts about each house. Listed below are ***some*** things you ***may*** want to consider during your visits as well as ***some*** of the questions you may want to ask the MHCRF Operator and staff during the visit. If you have other questions about the home, you should ask the MHCRF operator and staff during your visit. Use of this form is voluntary. If you have questions about how to use this form, or what to expect during your MHCRF visit/interview, you should talk with your representative or CSA/ACT Team.

	NAME OF RESIDENCE	CONTACT PERSON/PHONE NUMBER	DATE OF VISIT
RESIDENCE A			
RESIDENCE B			
RESIDENCE C			

	Residence A Yes/No	Residence B Yes/No	Residence C Yes/No
Is the general atmosphere warm, pleasant & cheerful?			
Do staff show genuine interest in and affection for residents?			
Do residents look well cared for and generally content?			
Is the residence clean and orderly?			
Is the residence free of unpleasant odors?			
Does the residence offer designated smoking areas?			
Does the food look appetizing with adequate serving sizes?			
Do residents who need help in eating receive assistance?			
Does the residence offer activities that you would enjoy?			
Do residents have an opportunity to attend religious services, and talk with their clergymen both in and outside the home?			
Do staff knock before entering a resident's room?			
Is there a room where residents can chat, read, play games, watch television or just relax away from their bedrooms?			
Does the residence have an outdoor area where residents can get fresh air and sunshine?			
Did the staff ask about your specific needs and preferences?			
Do you have enough information about this residence to make a decision?			
Would you be satisfied with living here?			

OCT 1 3 2022

Resident/Representative Belongings Packing Check List

Resident Name:______________________ CSA/ACT Team:________________

Move-Out Date:______________________ New Placement:________________

This form should be used by the Resident/Representative to confirm that ***all*** of the Resident's belongings have been packed before leaving the MHCRF. Please put an "X" next to each item after verifying that it was packed for the Resident's new placement.

CLOTHING		**TOILETRIES AND PERSONAL**	
Socks/Hose		Toothbrush/ toothpaste	
Shoes/Slippers		Dentures	
Bedclothes – pajamas/robe		Cosmetics	
Underwear		Deodorant	
Shirts/Blouses		Comb/Hairbrush	
Jeans/Sweats/Pants		Shaving soap/shaver	
Suits		Soaps	
Skirts			
Slacks		**ELECTRONICS**	
Dresses		Cellphone and charger	
Sweaters /Sweatshirts		Computer/laptop/tablet and charger	
Jackets/Vests		Camera	
Hats/Caps		TV and TV remote	
Coats/Raincoats			
Boots		**BOOKS AND PAPERS**	
		Photos	
ACCESSORIES		Books/Magazines	
Belts/Suspenders		Personal Papers	
Handbags/Shoulder Bags/Brief cases		Address Book	
Jewelry		Pens/Pencils	
Watches/Clocks			
		FURNITURE/WALL HANGINGS	
PERSONAL ITEMS		Table	
Wallet		Wall Art	
Handbag		Chair	
Keys		Other furnishings	
Cell phone			
Medication/Vitamins			

OCT 1 3 2022

Recommendations to Support Residents During the Moving Process

Residents may need additional supports during the moving process. The resident's representative and/or natural supports, and the CSA/ACT Team should escort the resident to their new residence. The CSA/ACT Team should inform all parties who are participating in the move of the date and time as soon as it is known. All parties participating in the move should consider the following steps:

1. Check if resident is prepared to go before the vehicle that will transport the resident to their new placement arrives (belongings packed, fully dressed, etc.);
2. Inform the resident when the vehicle arrives;
3. Load the resident's belongings into the vehicle and inform them that ***all*** of their belongings have been securely packed into the vehicle for transport;
4. Allow the resident ample time to say good-bye to other residents and staff;
5. Adjust the vehicle's temperature for the resident (air conditioning or heat);
6. Escort the resident at their pace to the transfer vehicle;
7. Comfort the resident:
    a. Talk calmly with the resident;
    b. Offer reassurance to the resident about the move; and
    c. Reduce the noise within in the vehicle – consider comforting music.
8. If using a wheelchair lift:
    a. Show the resident how it works;
    b. Explain to the resident what to expect (noise, movement, etc.); and
    c. Offer to ride on the lift with the resident, if acceptable to the driver.
9. When entering a bus or passenger van, point out the railings and steps to the resident;
10. If multiple residents are transferring on the same vehicle, consider staying on the bus with the residents while others are boarding;
11. Once at the new residence, assist the resident into the building;
12. Stay with the resident while their belongings are being unloaded; and
13. Offer to assist the resident in setting up their room.

OCT 1 3 2022

Person-Centered Discharge Planning Form

Resident Name: ______________________ Room Number: ________________

CSA/ACT Team: ______________________ Does Resident Smoke? Yes or No

---

TO BE COMPLETED BY THE CSA/ACT TEAM WITH THE RESIDENT

What type of setting would you like to live in? (return home, live with family, CRF, MHCRF, NF, etc.)

What are the most important things to you about this new placement? (privacy, location, etc.)

What makes you happy?

What do you enjoy doing?

How do you like your day to go? Describe your typical day

What specific preferences do you have for care delivery? (bath vs. shower, meals/day, caregiver gender)

What is your lifestyle like? (morning vs. night person, introvert vs. extrovert, alone vs. group activities)

Any other needs/preferences?

OCT 1 3 2022

What is your past or current religious affiliation(s) or denominations?

Spiritual or religious activities are ☐ Very important ☐ Somewhat important ☐ Not important at all

Support System (family, friends, neighbors, religious or community members, staff)

Important Events (anniversaries, births, deaths)

Nicknames

Hobbies

Skills

Schooling (level completed, where)

Occupation (company, how long, retired)

Veteran (war time, branch of service)

Community Organizations

OCT 1 3 2022

Family (spouse, children, grandchildren)

___

___

___

Who would you like to participate in your move?

___

___

___

How would you like to be welcomed at your new residence? (visitors, be left alone, announcement, attend activities, etc.)

___

___

___

Name of Person who Completed Section:________________ Date:________________

INSIGHT INTO RESIDENT'S QUALITY OF LIFE (completed by MHCRF Residence Director)

What is the resident's preferred daily routine? (waking time, social interactions, nighttime activity, etc.)

___

___

___

What is comforting to the resident? (type of music, certain activities, food items, possessions, etc.)

___

___

___

Does the resident have favorite special foods or treats? (supplied by family/staff, etc.)

___

___

___

What environment supports are available for the resident? (likes to sit by the window, prefers room door shut, sleeps with the lights on, etc.)

___

___

___

What emotions or situations trigger the resident? (Stressors, excitement, sadness, depression, outbursts)

___

___

___

OCT 1 3 2022

Specific times or days it occurs?

____

____

____

Effective Interventions?

____

____

____

SCREEN FOR RESIDENTS FUNCTIONING (completed by MHCRF Residence Director)

Bathing Assistance	□ Independent	□ Partial Assistance	□ Total
Hygiene Assistance	□ Independent	□ Partial Assistance	□ Total
Dressing Assistance	□ Independent	□ Partial Assistance	□ Total
Telephone Use Assistance	□ Independent	□ Partial Assistance	□ Total
Shopping Assistance	□ Independent	□ Partial Assistance	□ Total
Food Prep Assistance	□ Independent	□ Partial Assistance	□ Total
Housekeeping Assistance	□ Independent	□ Partial Assistance	□ Total
Laundry Assistance	□ Independent	□ Partial Assistance	□ Total
Transportation Assistance	□ Independent	□ Partial Assistance	□ Total
Finances Assistance	□ Independent	□ Partial Assistance	□ Total
Mobility Assistance	□ Independent	□ Partial Assistance	□ Total
Eating Assistance	□ Independent	□ Partial Assistance	□ Total
Continence Assistance	□ Independent	□ Partial Assistance	□ Total

Check if applicable

- ❑ Dependent for feeding
- ❑ Incontinence Bowel _____ Bladder _____
- ❑ Dependent for bathing
- ❑ Dependent for dressing
- ❑ Elopement Risk Explain ________________________________
- ❑ IV Therapy
- ❑ Infection: Acute__________ or Chronic __________ Type ______________
- ❑ Needs Oxygen
- ❑ Dependent Transfer x1_____ x2_____ Mechanical Lift _____
- ❑ Wheelchair for Mobility
- ❑ Communication Aids (interpreter, communication board, sign language, hearing aid, etc.)

OCT 1 3 2022

____

- ☐ Special Needs or Equipment

____
____

Upcoming appointment (doctor's name, purpose of visit or procedure, date, time, location, phone number)

____
____
____

Name of Person who Completed Section:____________________ Date:____________________

OCT 1 3 2022

DBH DEPARTMENT OF BEHAVIORAL HEALTH

MHCRF APPLICANT DENIAL FORM

Operator: ______________________________

MHCRF Address: ______________________________

____

Telephone/Email: ______________________________

Applicant Name: ______________________________

CSA: ______________________________

Date: ______________

Denial Justification: ***(Chapter 38 - Regulation 3825: General Eligibility of Admission Requirements)***

______________________________ ______________________

Signature **Date**

Please return form to:

Alvin Hinkle, MSW, CPM, Director – Residential Support Services at alvin.hinkle@dc.gov

Drew L. Sweat, MA, Director of Licensure, Accountability Administration at drew.sweat@dc.gov