**Consumer Name:** **DOB:**

**Date of Referral:** Click here to enter a date. **Facilitator:** Choose an item.

**Screening Appointment in CST:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Financial Form \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Application and Admission to Program \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Releases of Information \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Medical Records \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Informed Consent for Treatment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Client Policies Form \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Texting Policy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Telehealth Consent \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* PPS in MyEvolv ­­­­ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* PPS in State System ­­­­ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**30 Day Deadline: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*(All paperwork to be completed 30 days from Application Date)***

* CANS Assessment
	+ Enter in State System \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Plan of Care \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	+ Hold First Team Meeting and Invite MHP

**6 Month Review Due: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** ­­

* Update Plan of Care \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* PPS in MyEvolv \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* PPS in State System ­­­­ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Yearly Review Due:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Financial Form \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Application and Admission to Program \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Authorization for Services Form \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Informed Consent for Treatment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Client Policies Form \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Texting Policy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Telehealth Consent \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Release of Information Forms \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Prescription Form \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Update PPS in MyEvolv ­­­­ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Review/Update CANS
	+ Update in State System ­­­­
* Review/Update Plan of Care ­­­­ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Discharge Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Discharge Summary \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* PPS in MyEvolv \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* PPS in State System \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Closed in CST in MyEvolv \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_