PerformCARE®

CRR-HH/RTF Provider Referral Response Form

Member's Name: _____ MAID#: _____

Member County:

☐ Cumberland ☐ Dauphin ☐ Franklin ☐ Fulton ☐ Lancaster ☐ Lebanon ☐ Perry

Provider Type: ☐ CRR ☐ RTF

Provider Name: _____ Provider Contact #: _____

Date Referral Received: _____

Provider Response:

☐ Accepted (Target Admission Date: _____)

☐ Denied (list reason(s) below)

☐ Age
☐ Autism Spectrum Disorder
☐ Disruptive Behavioral Risk
☐ Female
☐ Geo-Access Issues
☐ Medical
☐ MH/IDD
☐ Psychosis
☐ Sexual Reactivity
☐ Significant Mental Illness
☐ Trauma
☐ Other: _____
☐ Animal Cruelty Risk
☐ Capacity
☐ Eating Disorder
☐ Fire Setting Risk
☐ Low Functioning
☐ Medical Assisted Tx
☐ MH/SUD
☐ Self-Harming Behaviors
☐ Significant Emotional Disturbance
☐ Specialty
☐ Traumatic Brain Injury
☐ Assault Risk
☐ Denied by Family
☐ Elopement Risk
☐ Gender Identity
☐ Male
☐ Member Acuity
☐ No Discharge Resource
☐ Sex Offending Risk
☐ Suicidal History
☐ Unit Acuity

Staff Completing Form: _____ Date: _____