



## A MONARCH PROGRAM

Club Horizon • 101 B Forest Drive • Knightdale, NC 27545  
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# REFERRAL PROCESS

THE FOLLOWING PAPERWORK SHOULD BE SUBMITTED FOR EACH REFERRAL:

1. Comprehensive Clinical Assessment (CCA) - all prospective members who have not previously been involved in a psychosocial rehabilitation (PSR) program should have a CCA or psychiatric evaluation completed prior to the referral with PSR listed as a recommended service.
2. Demographic information including diagnosis, medication, and clinical documentation from the provider of clinical services.
3. Person Centered Plan (PCP) which includes orientation goal for Club Horizon or social and vocational goals, if appropriate. PSR must also be included as one of the recommended services on the person centered plan. The signature sheet must be dated within the past 30 days for Club Horizon to request initial authorization.
  - \* PCP reviews are required every six months with Club Horizon representative in attendance. The clinical home or lead agency should update PCP to reflect any changes and submit a copy to Club Horizon 3 weeks prior to 6 month and 12 month review date.
  - \* If Club Horizon is considered the new clinical home, the PCP will be completed during the referral process.
4. Medicaid number, as applicable. When a prospective member is not eligible for Medicaid, Fee application must be completed to request IPRS funding.  
(Club Horizon does not deny anyone who meets eligibility criteria from becoming a member due to lack of insurance or inability to meet Medicaid or IPRS funding.)

**TOUR & TRIAL DAYS:** Once the above information is received, Club Horizon looks to see if the basic eligibility requirements are met. If they are, we contact the potential member and invite them out for a tour. If the person would like to continue, we have them come out for three trial days. This is an opportunity for the person to ensure this is their chosen service for PSR.

**PCP & AUTHORIZATION:** Once the trial days are completed, the potential member meets with the Program Director and discusses the desire to move forward. If the person would like to attend our clubhouse, we send the referral paperwork to Monarch for intake and schedule for a Qualified Professional to complete a PCP, if we are the clinical home, and the Initial Authorization.

**TRANSPORTATION:** Medicaid recipients who live in a private residence are eligible for transportation to and from the clubhouse. Club Horizon will work with the referring agent to ensure that prospective members are able to attend the clubhouse immediately after all paperwork is complete and the authorization for transportation is obtained.

**REFERRALS:** Club Horizon welcomes referrals from all sources including, Wake County Human Services, psychiatric hospitals, the private (outpatient) sector, family members and existing Club Horizon members. In all referrals, Club Horizon asks that the referral agents work collaboratively with the program staff to better ensure continuity to care for the potential member.

## **CLUB HORIZON ELIGIBILITY CRITERIA:**

1. Does the potential member have one of the following Severe and Persistent Mental Illnesses (SPMI): Schizophrenia, Schizoaffective Disorder, Bipolar, Major Depression, etc.?
2. Is the person a Wake County resident?
3. Are any/all medical conditions currently managed?
4. Is the person seeking social or vocational supports or opportunities?
5. Is the person 18 years of age or older?
6. Does the person have a desire to be an active participant in a supportive, vital community?



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**CLUB HORIZON REFERRAL FORM**  
Psychosocial Rehabilitation Services

Client Name: \_\_\_\_\_ Date of Referral: \_\_\_\_/\_\_\_\_/\_\_\_\_

Medicaid #: \_\_\_\_\_ Record#: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M F

Home Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Current Address: \_\_\_\_\_

Parent/Guardian Full Name(s) (If applicable): \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Current Address: \_\_\_\_\_

**Other Services Provided:**

Therapist: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Psychiatrist: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Referring Program: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

**Presenting Problem(s) / Reason for Reason for Referral:**

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**DSM-5 Diagnoses:**  
(Please include codes and descriptions)

(**must** assess further for clubhouse compatibility if there is a Developmental Disability or Intellectual Developmental Disability)

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Medical Conditions:

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Current Medications:

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History of any of the following behaviors: (circle) Abusive / Violent / Sexually Inappropriate

Additional information (include any history of hospitalizations):

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Referral Recommendations:

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Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_