90-100 APPENDIX B. REFERRAL FROM CMH DISCHARGE PLANNER

GRAM County of San Diego Health and Human Services Agency

TO: HHSA GR FRC_____ FROM: CMH DISCHARGE PLANNER___ DATE:_____

RE: _____ CASE NUMBER:_____

This is to refer CMH client (name)_____ to you for a GR eligibility determination. This person is currently in our care, but will be released to an independent living situation on (date)_____. It is understood that GR cannot be paid until this person is released, however, please process an application so that we will know whether or not he/she is eligible. A release of information signature is included below.

Living Arrangement: Address:_____
Phone:_____ Move in Date:_____
Cost: Rent $_____ or Room & Board $_____
Landlord:_____

Thank you

_____ _____
CMH Discharge Planner Phone

I hereby give the Health and Human Services Agency permission to discuss my housing arrangements and General Relief status with my CMH Discharge Planner.

_____ _____
Client's Signature Date