DMH Referral Form

Branch of Coordinated Care

SPECIALIZED PLANNING OPTIONS TO TRANSITION TEAM (SPOTT)

Referring Person/Agency:
Phone Number:
Date of Referral: Click here to enter a date.
IDENTIFYING INFORMATION
Name: County of Residence:
Date of Birth: Sex: Race:
Does this person have a guardian (conservator/power of attorney)? **Yes**_____ **No** _____
If yes, contact information: Name & Phone No.
Number of Admissions to Facility:
Community Mental Health Center Prior to Admission/Case Manager (if applicable):
FINANCIAL RESOURCE POTENTIAL (payment source)
Benefits: **Yes**_____ **No**_____ If yes, what type? **SSI**_____ **SSDI**_____ **VA**_____
If no, have they been applied for? **Yes** ____ **No** _____ If yes, date applied: Click here to enter a date.
INFORMATION ABOUT PERSON
Diagnosis:
Medications: Please note all medications including injections:
Why is this case being presented to SPOTT?
What are the recommendations of the treatment team?
List the placement options and timelines that have been tried for the individual:
Is the individual homeless? Yes _____ No _____

Return to MDMH via
Email Beverly.Magee@dmh.ms.gov
OR fax-601-359-9570

This Identification & Referral Report does not represent a binding decision nor does it represent a commitment by SPOTT to serve in placing the person receiving services.