

ATTACHMENT C REFERRAL NOTIFICATION

Participant's Name:	
DCN or DOB:	Nursing Facility Admission Date:
Check those that app	ly below:
Options	S Counseling Services were not provided
Options	S Counseling Services have been provided but LOC assessment is not indicated
Particip	ant is not interested in transition services
If additional space is r	needed for explanation (beyond information in the SMH system):
Options Counselor: _	Date:
	SEND TO THE DSDS SMH REGIONAL COORDINATOR