SHOW-ME HOME

APPROVAL NOTICE

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| **PARTICIPANT INFORMATION** |
| Name (please print or type): | DCN: | Date: |
| **MHD Reinvestigation Date: Reported Income:****Housing Preferences:** |  |  |  |  |
| **Substance Abuse History:** |  |  |  |  |
| **Criminal History:** |  |  |  |  |
| **Challenges to Transition:** |  |  |  |  |
| **Financial Issues:** |  |  |  |  |
| **Community Supports Needed:** |  |  |  |  |
| **Health Conditions/ Issues:** |  |  |  |  |
| **HCBS Needs:** |  |  |  |  |
| **Facility/ Staff Reports:** |  |  |  |  |
| **Miscellaneous Information:** |  |  |  |  |
| **SMH SERVICES SPECIALIST** | **Telephone Number** | **E-mail Address** |
|  |  |  |

**Note:** Transition plan must be complete and approved by the SMH Services Specialist before transition from the facility can occur. Appropriate backup strategies are considered a priority for approving the Transition Plan.

Attachment: SMH Participation Agreement

(08-22)