North Sound Mental Health Administration
Regional Support Network for Island, San Juan, Skagit, Snohomish, and Whatcom Counties
Improving the mental health and well being of individuals and families in our communities
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North Sound Mental Health Administration (NSMHA)
Request for Roads to Community Living (RCL) Resources

RCL funds are for supports provided to Medicaid eligible consumers discharging from qualified institutional settings to support recovery by ameliorating symptoms, prevent the need for future hospitalizations and/or residential treatment and are not funded by a more appropriate/any other system or resource. NSMHA will authorize RCL for individuals who meet the eligibility criteria, have identified, qualifying unmet needs stated in the transition care plan and are not otherwise provided for by Medicaid or a more appropriate system/provider.

Please fill out and submit this form to NSHMA ***prior*** to having youth / family sign the RCL Participation Form.

Today's date:	**Expected date of discharge:**	
Youth Name:	**DOB:**	**Gender (check)**: ☐ M ☐ F
Youth Discharge Address (city, state, zip):		
Youth SSN:	**Youth Provider One #:**	

Parent/Legal Guardian Name(s):		
Parent/Legal Guardian Address (city, state, zip):		
Home Phone:	**Cell Phone:**	**Other:**

It is important to establish providers, programs or services a youth is or will be engaged in after discharge in order to identify gaps. ***Please indicate this by placing a check mark in the applicable boxes***.

Type of Provider/Program/Service

	Mental Health & Psychiatry		**Residential / Children's Administration**
☐	Outpatient Mental Health Provider/Therapist	☐	Home/Relative Care
☐	Psychiatrist	☐	Foster Care
☐	Intensive Outpatient Mental Health Provider/Program	☐	Group Home
☐	Other:	☐	BRS
☐	Other:	☐	Other:
	Medical		**Educational**
☐	Primary Care Physician (PCP)	☐	School
☐	Other:	☐	IEP or 504
☐	Other:	☐	Other:

Legal Involvement	
☐	Probation
☐	Other:
☐	Other:

The following requested information is to determine the specific service/item being requested.

Please type responses to the following questions in the space provided. Do not leave blanks.

Please provide clinical rationale for how the requested service/item will support the treatment goals and identified needs?
Have all resources to fund the requested service/item (e.g. scholarships, other system funding responsibility, etc.) been explored and exhausted?
Does the family already have a provider in mind in their local community to deliver the requested service? *(If so, please give name, credentials and contact information)*
Please outline the specific costs of the requested service/item.