CENTRAL FLORIDA CARES FACT REFERRAL FORM

Name of person discharged: _____ SS# _____ DATE _____

THIS SECTION TO BE COMPLETED BY FACT TEAM

___ 1. The participant moved outside of the geographic area(s) of the FACT Team responsibility
____2. The participant demonstrates an ability to perform successfully in major role areas (i.e., work, social, and self-care) over time without requiring assistance from the program

____3. The participant requests discharge, despite the team's repeated efforts to develop a recovery plan acceptable to the participant.

___4. The participant has been admitted to a state mental health treatment facility and has remained in such facility for a period exceeding one year, and there is no anticipated date of discharge.

____5. The participant has been adjudicated guilty of a felony crime and subsequently sent to a state or federal prison for a sentence that exceeds on year.

___6. Other: Whereabouts unknown for a period exceeding ninety days

THIS SECTION TO BE COMPLETE BY THE FACT TEAM

FACT Staff processing discharge: _____

___Reason(s) for discharge: Client's whereabouts unknown for a period exceeding ninety days

Discharge Date to FACT program: _____ County Served: _____

THIS SECTION TO BE COMPLETED BY THE MANAGING ENTITY

ME Staff: _____ _____ Signature: _____
(Print Name)

Date: _____ ____ DISCHARGE APPROVED ____ DISCHARGE DENIED

IF DENIED, PLEASE GIVE REASONS: _____

_____

_____