

INVOLUNTARY COMMITMENT TRANSITION PLANNING REQUEST

*This form should be completed with the provider and client, typed, and submitted to BHA for approval one week prior to the anticipated transition date. BHA will review, and if approved, sign the request and return it to the provider. Clients should not be discharged without BHA approval. If the plan is not approved, BHA will communicate concerns with the provider.

DATE OF ANTICIPATED DISCHARGE FROM CURRENT RESIDENTIAL TREATMENT PROGRAM:
NAME OF TREATMENT PROGRAM AND THERAPIST:
CLIENT NAME:
CLIENT PHONE NUMBER:
CLIENT PERMANENT ADDRESS:
CLIENT EMAIL: IF CLIENT DOES NOT HAVE AN EMAIL ADDRESS, PLEASE HELP THEM SET ONE UP.
CLIENT TRANSITION ADDRESS:
WHO WILL YOU BE LIVING WITH:
IF SOBER LIVING PROVIDE THE HOUSE NAME AND NUMBER OF HOUSE MANAGER: Sign a release of information for Signal or Diversus Health and BHA IC Program for sober living facility, if applicable.
ARE YOU EMPLOYED? IF YES, PROVIDE NAME OF EMPLOYER:
IS CLIENT ON A MEDICATION ASSISTED THERAPY? IF YES, WHAT MEDICATION: IF YES, WHERE IS CLIENT RECEIVING THEIR MEDICATION ASSISTED THERAPY:
DOES CLIENT HAVE A PEER/RECOVERY COACH? IF YES, NAME OF PEER/RECOVERY COACH AND THE PEER ORGANIZATION, CONTACT NUMBER AND EMAIL
IOP PROGRAM AND THERAPIST NAME:
PAYOR SOURCE FOR IOP PROGRAM:
INTAKE DATE (Intake must be completed prior to discharge):
DATE OF INITIAL SESSION (An initial session should be completed prior to discharge):
IOP SCHEDULE:
WHERE IS CLIENT COMPLETING MONITORED SORRIETY TESTING?



CLIENT RESPONSIBILITY:	
If any of your contact information changes, please update your treatment provider and email BHA at cDHS_BHA_IC@state.co.us and provide new contact information immediately. Good luck in your next phase of treatment!	
Client signature	Date
BHA Signature for approval	Date