

DEPARTMENT OF MENTAL HEALTH  
NOTIFICATION OF OUT-OF-AREA MOVE OR PLACEMENT

1. Sending Area	2. Area Director	Date:
<hr/>		
3. Sending Area Contact Person	4. Telephone	
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5. Receiving Area	6. Area Director	
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7. Receiving Area Contact Person	8. Telephone	
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9. Client Information:		
_____ Client Name		_____ Date of Birth
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Last Known Address		
<hr/>		
New Address (e.g., residential program, placement, apartment, etc.)		
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Last Psychiatric Hospitalization (if known)		
_____ (facility)		_____ (discharge date)
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10. Legal Information - check and complete all that are applicable:		
Temporary Guardian/Permanent Guardian/Temporary Conservator/Permanent Conservator (circle one)		
(ATTACH COPY) Expiration Date (if applicable): _____		
Name/Address/Telephone: _____		
Treatment Order (ATTACH COPY) Expiration/Review Date (if applicable): _____		
Court: _____		Docket Number: _____
Rogers Monitor Name/Address/Telephone: _____		
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Representative Payee Name/Address/Telephone: _____		
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Custodian (e.g. DSS, if any) _____		Responsible Local Educ. Auth. _____
Contact/Phone: _____		Contact/Phone: _____
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11. Reason for Move or Placement:		
_____		
<hr/>		
12. Date of Move/Placement: _____ Change in AOR? No Yes Will change after 6 months		
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13. <u>Services Needed or Requested by Client (as per ISP):</u> (to be completed by sending Area)		<u>Services Receiving Area Will Provide (as per ISP):</u> (to be completed by receiving Area)
_____		_____
_____		_____
_____		_____
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14. SIGNATURES:		
_____ (sending Area Director)		_____ (date)
_____ (receiving Area Director)		_____ (date)
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<b>MUST BE RETURNED TO SENDING AREA BY RECEIVING AREA WITHIN THIRTY DAYS</b>		