ALTSA Subsidy – Acute Care Hospital Referral Form

LTC Case Managers are to complete this form with client and return to hospitalsubsidy@dshs.wa.gov.

Date Submitted:	**Client Name:**	**ACES ID:**
Referring CM:	**CM Supervisor:**	**County client wants to live in:**
# People in Household:	**Client Age & DOB:**	**Client Phone #:**

Eligibility Criteria		
YES ☐	**NO** ☐	**1. Is your client currently in an Acute Care Hospital?** *If no, client is not eligible*
☐	☐	**2. Has this client been found financially and functionally eligible for Long-Term Services and Supports?** *If no, client is not eligible*
☐	☐	**3. Is the client currently on an Involuntary Treatment Act (ITA) hold or have they transitioned or were diverted from Western/Eastern State Hospital within the past 18 months?** *If so, this client may be eligible for GOSH and will be screened for GOSH first*
☐	☐	**4. Does the client want Supportive Housing services?** *Supportive Housing (yes answer) = long-term tenancy support, includes housing search*
Informational Questions		
☐	☐	**5. Is the client enrolled in Roads to Community Living (RCL)?** **Enrollment Date:** **Anticipated Discharge Date:**
☐	☐	**6. Does the client have a valid ID and Social Security card?**
☐	☐	**7. Does the client have any source of income?** *If not, is there a plan to apply for ABD upon discharge?*