

**RESIDENTIAL REHABILITATION PROGRAM
DISPOSITION FORM**

Consumer's Name _____

Consumer MA# (or SS# if no MA) _____

Date assessment Completed _____

I. Consumer is accepted for Residential Placement.

(a) Preferred Level: Intensive _____
General _____

(b) Projected Date of Placement _____

(c) Address of RRP Residence _____

(d) Brief Summary of Assessment and Service Needs.

(e) Is off-site PRP requested? Yes___ No___ How many units per week? _____

If the Consumer is not accepted for Residential Placement. Please state reason below:

Signed _____ Date _____

Agency _____ Phone _____

*Please fax this form to the CSA within 10 days of receipt of referral.