**Macomb County Community Mental Health**

**Placement Review Committee Request**

Person Served:      MCCMH Case Number:

Date of Request:

Person’s Current Location:

How long have they been at the current location:

Has the person served been given a discharge notice from another SRS setting? Yes No

If yes, provide specific details regarding the reason for the discharge:

If they are in a hospital, are they ready for discharge? Yes No

If not ready for discharge, provide specific details as to their status:

Describe all actions previously taken to secure a residential placement and the outcomes of those actions:

Requestor’s Name:

Provider Agency Name:

Email:

Phone Number:

**Submit this form to PlacementReviewCommittee@mccmh.net**

**Admin Section**

Placement Review Committee appropriate? Yes No

Date presented at PRC:

Providers that scheduled PPVs and the outcome of the referrals:

Placement date:       Residential Provider: