



Admissions Info Sheet

Admissions Department Contact

Sarah Testa, LCSW, Admissions Director
501-303-3109 office | 501-631-3794 fax

sarah.testa@birchtree.org

Send referrals to sarah.testa@birchtree.org OR

fax to 501-631-3794

Birchtree.org/admissions

Birch Tree Communities, Inc. is a community-based program which provides housing and day treatment for adults (18+) diagnosed with a serious mental illness. We primarily see adults diagnosed with:

- Schizophrenia
- Bipolar Disorder
- Schizoaffective Disorder

Please call our Admissions Department with any questions regarding eligibility or to check the status of your application.

Court orders are not necessarily a guarantee of acceptance into our program. All applicants must be approved by our Admissions Committee which consists of our CEO, CCO, CCO, Admissions Director, Director of Nursing, and our Medical Director.

Applicants must also provide income and asset verification in order to qualify for coverage and housing. All admissions must be assessed and tiered by one of the four Arkansas PASSE's or qualify for Spend Down.

Birch Tree Communities, Inc. is not an emergency/crisis/acute care facility. If you or a loved one needs immediate help, please call 911 or visit your nearest emergency department for help.

How do I get the process started and what do I need?

Make sure you have the following before pursuing the Admissions Process:

1. Patient's Name
2. Social Security Number
3. Date of Birth
4. Proof of US Citizenship
5. Social Security Monthly Benefits
6. Property ownership (this affects HUD eligibility)
7. Bank account info (this affects HUD eligibility)
8. Tiered, and assigned to a PASSE (Only clients assigned to Tier 2 or Tier 3 are eligible for admission.)
9. Documentation supporting the referral from a current mental health provider and primary care provider

Once you have this information, send the initial Referral Form to the Admissions Department via fax or email.

Before the individual is presented to the Admissions Committee, we will also want to see a psychiatric evaluation, medication list, health and physical, lab work, and some form of treatment history and current participation via progress notes

Birch Tree Communities, Inc. cannot accommodate the treatment needs for applicants requiring:

- Skilled Nursing Programs
- Waiver Services
- Sex Offender Registration



Initial Referral Form PLEASE COMPLETE EVERY SECTION

Date of Referral	Name of Person Making the Referral	Agency/Hospital/Relation to Client	Phone #
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Email

Client/Patient Info

Full Name: _____

First	Middle	Last
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DOB: _____ SS#: _____ Gender: _____ Race: _____

Total Monthly Income: \$ _____ Source of Income (SSI, SSDI, VA Benefits) with amounts: _____

Client/Patient Contact Info: _____

Client/Patient consents that Birch Tree Communities, Inc. will become his/her payee: YES NO

Marital Status: _____ Education: GED High School Diploma Some College College Graduate

Is client a legal US citizen? YES NO

Previous member of Birch Tree Communities, Inc.? YES NO

Primary Diagnosis _____

Secondary Diagnosis _____

Is the client assigned to a PASSE? YES NO/Unsure _____

PASSE Name	Tier Level
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If No/Unsure, has an Optum Assessment been requested? YES NO

Where has client sought Mental Health treatment? Please provide ROI.

Is client on any type of court order? YES NO If yes, what type? _____

Does the client have a legal guardian? YES NO If yes, _____

Name & Phone Number

Does the client have a bank account? YES NO If yes, what bank? _____

(If yes, to be HUD eligible, we'll need access to six months of bank statements)

Does the client own any property (home, vehicle, land)? YES NO

If YES, what type? _____

With this form, also send:

- Psychiatric evaluation
- Medication List
- Progress notes
- Labs
- Copy of Court Order (if applicable)
- Copy of Guardianship (if applicable)
- History & Physical
- Release of Information (ROI)
 - Make as many copies as needed.
 - PLEASE NOTE: one ROI form per provider/family member.
 - Include Social Security Administration.



Birch Tree
COMMUNITIES

AUTHORIZATION TO RELEASE INFORMATION

PO Box 1589
BENTON AR 72018
501-345-3344
WWW.BIRCHTREE.ORG

I, _____, _____, _____ **Authorize**
Individual Date of Birth Social Security #

Birch Tree Communities, Inc to **Disclose** **Obtain Information**

To/from: _____
Name, address, phone, email

for the Purpose of: Continuity of Care Referral Individual/ Guardian Request Legal
 Other _____

Records to be obtained/disclosed (please check and initial):

- | | |
|--|---|
| <input type="checkbox"/> ___ Psychiatric Eval | <input type="checkbox"/> ___ Aftercare/ Discharge Summary |
| <input type="checkbox"/> ___ Medication Management Notes/MAR | <input type="checkbox"/> ___ Face Sheet/Demographic Information |
| <input type="checkbox"/> ___ Mental Health Evaluation | <input type="checkbox"/> ___ Tuberculosis Skin Test Results |
| <input type="checkbox"/> ___ Current Treatment Plan/Review | <input type="checkbox"/> ___ Verbal/ Written Communication |
| <input type="checkbox"/> ___ Presence/Participation in Treatment | <input type="checkbox"/> ___ Psychotherapy Notes (cannot be combined with another disclosure) |
| <input type="checkbox"/> ___ Progress Notes | <input type="checkbox"/> ___ Other (specify) _____ |
| <input type="checkbox"/> ___ Physical/ Vitals/ Lab Work | |

I am aware that my records may contain sensitive information regarding my mental health, alcohol/ substance use, and health diagnoses including HIV/ AIDS/ communicable diseases. I am aware this form is regulated by the *Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2*. The handling of my health information is also regulated by the *Health Insurance Portability & Accountability Act, 45 C. F. R. Parts 160 & 164*. I am aware of my right to decline signing this form. I understand that my treatment will not be conditioned on my authorization unless medically necessary. Unless otherwise specified, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format and electronically. I understand that there is a potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information. This authorization does not give permission to re-disclose my information to other organizations without my express permission. I am aware that there are certain federal exceptions to redisclosure in which my information may be distributed for coverage, legitimate legal inquiries or to address a genuine medical emergency.

This authorization expires in one year or on date: _____ (less than 1 year). I understand that I have the right to revoke this authorization in writing at any time by sending written notification to Birch Tree Communities at the address or email address listed above.

I have read this form and agree to the uses and disclosure of the information as described:

Member/Individual Signature Date Printed Name

Guardian Signature Date Printed Name

Witness Signature Date Printed Name



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Records to be obtained/disclosed (please check and initial):

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- ___ Medication Management Notes/MAR
- ___ Mental Health Evaluation
- ___ Current Treatment Plan/Review
- ___ Presence/Participation in Treatment
- ___ Progress Notes
- ___ Physical/ Vitals/ Lab Work
- ___ Aftercare/ Discharge Summary
- ___ Face Sheet/Demographic Information
- ___ Tuberculosis Skin Test Results
- ___ Verbal/ Written Communication
- ___ Psychotherapy Notes (cannot be combined with another disclosure)
- X ___ Other (specify) electronic communication

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