Admissions Info Sheet

Admissions Department Contact
Sarah Testa, LCSW, Admissions Director
501-303-3109 office l 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 (primarily 21+) 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

Birch Tree COMMUNITIES

SEND TO:
Sarah Testa, LCSW, Admissions Director
501-303-3109 office | 501-631-3794 fax
Sarah.testa@birchtree.org

Initial Referral Form *PLEASE COMPLETE EVERY SECTION*

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

______________ Email

Client/Patient Info

Full Name: ______________ First ______________ Middle ______________ Last

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

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.**

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: Social Security Administration____

Name, address, phone, email

for the Purpose of: □ Continuity of Care **X** Referral □ Individual/ Guardian Request □ Legal
□ Other____

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

- □ __ Psychiatric Eval
- □ __ 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______

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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I, ______________________________, _________________, __________________ Authorize
Individual Date of Birth Social Security #

Birch Tree Communities, Inc to ☐Disclose X Obtain Information

To/from: ____
Name, address, phone, email **PROVIDE CONTACT INFO FOR INPATIENT ACUTE ADMISSION**

for the Purpose of: □ Continuity of Care **X** Referral □ Individual/ Guardian Request □ Legal
□ Other____

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

□ **X**_ Psychiatric Eval
□ **X**_Medication Management Notes/MAR
□ __ Mental Health Evaluation
□ __ Current Treatment Plan/Review
□ **X**_ Presence/Participation in Treatment
□ **X**_ Progress Notes
□ **X**_ Physical/ Vitals/ Lab Work
□ **X**_ Aftercare/ Discharge Summary
□ **X**_ Face Sheet/Demographic Information
□ **X**_ Tuberculosis Skin Test Results
□ **X**_ Verbal/ Written Communication
□ **X**_ Psychotherapy Notes (cannot be combined with another disclosure)
□ __Other (specify)____________________________

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______________________________________ _____________________ _________________
Member/Individual Signature Date Printed Name

______________________________________ ______________________ _________________
Guardian Signature Date Printed Name

______________________________________ ______________________ _________________
Witness Signature Date Printed Name

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Individual Date of Birth Social Security #

Birch Tree Communities, Inc to ☐Disclose X Obtain Information

To/from: ____

Name, address, phone, email **PROVIDE CONTACT INFO FOR CURRENT MENTAL HEALTH PROVIDER**

for the Purpose of: □ Continuity of Care **X** Referral □ Individual/ Guardian Request □ Legal
□ Other____

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

- □ **X_** Psychiatric Eval
- □ **X** Medication Management Notes/MAR
- □ __ Mental Health Evaluation
- □ __ Current Treatment Plan/Review
- □ **X_** Presence/Participation in Treatment
- □ **X_** Progress Notes
- □ **X_** Physical/ Vitals/ Lab Work
- □ __ Aftercare/ Discharge Summary
- □ **X_** Face Sheet/Demographic Information
- □ __ Tuberculosis Skin Test Results
- □ **X_** Verbal/ Written Communication
- □ **X_** Psychotherapy Notes (cannot be combined with another disclosure)
- □ __Other (specify)_____________________________

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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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I, _____________________________, ________________, _________________ Authorize
Individual — Date of Birth — Social Security #

Birch Tree Communities, Inc to ☐Disclose X Obtain Information

To/from: ____
Name, address, phone, email **PROVIDE CONTACT INFO FOR PRIMARY CARE PROVIDER**

for the Purpose of: □ Continuity of Care **X** Referral □ Individual/ Guardian Request □ Legal
□ Other____

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

- □ __ Psychiatric Eval
- □ **X**_Medication Management Notes/MAR
- □ __ Mental Health Evaluation
- □ __ Current Treatment Plan/Review
- □ __ Presence/Participation in Treatment
- □ **X**_ Progress Notes
- □ **X**_ Physical/ Vitals/ Lab Work
- □ __ Aftercare/ Discharge Summary
- □ **X**_ Face Sheet/Demographic Information
- □ **X**_ Tuberculosis Skin Test Results
- □ **X**_ Verbal/ Written Communication
- □ __ Psychotherapy Notes (cannot be combined with another disclosure)
- □ __Other (specify)____________________________

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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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I, ______________________________, _________________, __________________ Authorize
Individual Date of Birth Social Security #

Birch Tree Communities, Inc to X Disclose X Obtain Information

To/from: ____
Name, address, phone, email **PROVIDE CONTACT INFO FOR FAMILY MEMBER(if applicable)**

for the Purpose of: □ Continuity of Care **X** Referral □ Individual/ Guardian Request □ Legal
□ Other____

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

- □ __ Psychiatric Eval
- □ __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
- □ **X**_ Verbal/ Written Communication
- □ __ Psychotherapy Notes (cannot be combined with another disclosure)
- □ __Other (specify)____________________________

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Member/Individual Signature Date Printed Name

______________________________________ _____________________ _________________
Guardian Signature Date Printed Name

______________________________________ _____________________ _________________
Witness Signature Date Printed Name

Birch Tree COMMUNITIES

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Individual Date of Birth Social Security #

Birch Tree Communities, Inc to X Disclose X Obtain Information

To/from: ____
Name, address, phone, email **PROVIDE CONTACT INFO FOR FAMILY MEMBER(if applicable)**

for the Purpose of: □ Continuity of Care **X** Referral □ Individual/ Guardian Request □ Legal
□ Other____

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

- □ __ Psychiatric Eval
- □ __Medication Management Notes/MAR
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______________________________________ ______________________ __________________
Guardian Signature Date Printed Name

______________________________________ ______________________ __________________
Witness Signature Date Printed Name