Department of Behavioral Healthcare, Developmental Disabilities and Hospitals
Mental Health Psychiatric Rehabilitative Residences
Admissions Department
14 Harrington Rd.
Cranston, RI 02920

Office: 401-462-1558
Fax: 401-462-1538

APPLICATION FOR ADMISSION

Name of Applicant:_____

Residence:_____

Date of Birth:_____ **Sex**: ☐ Male ☐ Female **U.S. Citizen**: ☐ Yes ☐ No **Religion**: _____

Marital Status: ☐ Single ☐ Married ☐ Civil Union ☐ Widowed ☐ Divorced **Current Legal Status**:_____

Race: ☐ White ☐ Black or African American ☐ American Indian ☐ Asian ☐ Native Hawaiian or other Pacific Islander ☐ Mixed

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino **Language Preference**: _____

INCLUDE PHOTOCOPIES OF ALL MEDICAL COVERAGE CARDS

Social Security #:_____ **Name of insured, if other than applicant**:_____

Medicare #:_____ Federal ☐ Medicare Replacement Plan (HMO) ☐ **Agency**:_____

If supplemental plan to Medicare please specify:_____ **ID #**:_____

Blue Cross #:_____ **Veteran's #**:_____ **Other**:_____

Medical Assistance #:_____ **ID #**:_____
(R.I. only) If pending, list name of office/worker to contact

Referral from (hospital, nursing home, community agency, etc.):

Name:_____ **Address**:_____

Contact Name:_____ **Telephone**:_____

Family, significant other supports

Name	**Address**	**Telephone (home/work/cell)**	**Relationship**

How often have family, significant other supports visited the applicant in the last two months?

☐ Daily ☐ 2-3 times per month
☐ More than a week ☐ Once a month
☐ Once a week ☐ Less than once a month ☐ N/A

How often have they provided care/assistance to the applicant in the last two months?

☐ Daily ☐ 2-3 times per month
☐ More than a week ☐ Once a month
☐ Once a week ☐ Less than once a month ☐ N/A

Advanced Directive: ***Please provide copies of any known "Advanced Directive".***

Living Will: ☐ Yes ☐ No
Durable Power of Attorney for Healthcare: ☐ Yes ☐ No
Is Guardianship pending? ☐ Yes ☐ No

Communication Preferences

☐ Mail
☐ Phone _____
☐ *Email_____

*No personal health information can be sent via email

_____
Applicant's Signature (If unable to sign, guardian or relative) Date

MHPRRs are facilities that provide Long-Term Care; patients accepted for admission ***must qualify for a group home level of care***. If / when clients no longer qualify for group home level services as determined by the treatment team, discharge to a less restrictive environment becomes mandatory under federal guidelines.

To be considered for placement in a MHPRR, an individual shall be eighteen (18) years or older and not under the jurisdiction of the Department of Children, Youth and Families, be diagnosed with a serious and persistent mental illness (i.e. meet the eligibility criteria for treatment in a Community Support Program), and demonstrate an inability to receive care and treatment in a less restrictive community setting by reason of his/her serious and persistent mental illness. Supporting documentation (i.e. treatment records) is required.

Identify which of the following priority placement criteria met by this client:

(a) A history of being incarcerated, or institutionalized, or in a controlled environment of any kind, including, but not limited to, admission to: the Eleanor Slater Hospital, the Forensic Service at the Eleanor Slater Hospital, or the ACI ;

(b) Exhibits dangerous behavior and/or has a history of violence that requires close supervision and a highly structured setting to ensure the safety of the individual and/or the community;

(c) Requires assistance to complete daily living and self-care tasks;

(d) A co-occurring physical health problem, developmental disability, and/or substance use disorder that requires more intensive treatment, monitoring, and support than can be provided in a less restrictive community setting;

(e) Has received care and treatment pursuant to a Court Order for Outpatient Treatment and the individual's compliance with said order; and

(f) The number of psychiatric hospitalizations in the past year. Number_____

Does the patient have a discharge goal after MHPRR? ☐ Yes ☐ No

If yes what is the goal: ☐ Home alone ☐ Assisted living

☐ Home with family

☐ Other (Please specify):_____

If no discharge goal exists, please explain long-term goals for this patient 1-5 years from now:

_____

_____

_____

_____

Who is the primary mental health treatment provider currently?_____

ALL INFORMATION MUST BE COMPLETE AND ACCURATE. PLEASE INCLUDE COPIES OF SUPPORTIVE DOCUMENTATION: *Physician progress notes, physician orders, nurses notes, consultations, therapists notes, etc.*

***To be completed by physician, nurse, or case manager* – please check appropriate boxes.**

MEMORY

☐ Normal
☐ Mildly impaired
☐ Moderately impaired
☐ Severely impaired

COMMUNICATION

☐ Normal
☐ Language barrier
☐ Comprehends
☐ Can relate needs
☐ Aphasic/non-communicative

BEHAVIOR

☐ No significant disorder
☐ Appears depressed
☐ Wanders
☐ Noisy
☐ Withdrawn
☐ Physically assaultive
☐ Verbally abusive
☐ Intrusive
☐ Combative during care
☐ Sexually inappropriate

SENSORY

☐ Hearing impairment
☐ Vision Impairment

DSM Diagnoses

I. _____ IV. _____

II. _____ V. _____

III. _____

MEDICATIONS (Dose & Routine)

_____ _____

_____ _____

_____ _____

_____ _____

PROGNOSIS ☐ Good ☐ Fair ☐ Poor ☐ Guarded

_____

_____

_____

PHYSICIAN VERIFICATION

Name of Physician:_____ Telephone:_____ Date of last examination:_____
(Print)

Signature of Physician:_____ Date:_____

This section to be completed by Group Home receiving application and returned to BHDDH

Date Client Assessed:_____

Results of Assessment:

1. **Client appropriate for group home, bed available, date to be placed _____**
2. **Client appropriate for group home, no bed available, anticipated date of placement_____**
3. **Client inappropriate for placement at group home.**

   Justification_____

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Signature of Agency Representative Title Date