REFERRAL PACKET CHECKLIST

Birch Tree Communities, Inc.

Admissions Department Contact
Riley E. S. Gambill, Admissions Director
501-303-3109 OFFICE | 501-303-3180 FAX

PO Box 1589 Benton, Ar 72018
riley.gambill@birchtree.org
www.birchtree.org/admissions

Birch Tree Communities is an outpatient program which provides housing and day treatment for individuals diagnosed with severe mental illnesses. We assist in transitioning members from supervised group homes to apartments and continued independence. Our mission is to provide "*a satisfying life in the community*" for all of our members.

Please call the Admissions Department with any questions regarding eligibility or to check the status of your application. Due to severity, Birch Tree prioritizes the placement of people leaving a short-term psychiatric hospitalization.

Court orders are not necessarily a guarantee of acceptance into our program; all applicants must be approved by our medical director for treatment.

Please be aware that if approved, every applicant will need a tuberculosis skin test prior to arriving. Applicants may also need to provide income and asset verification in order to qualify for coverage and housing.

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

☐ **Referral Form** & **Financial Information** forms
-or- **Provider Face Sheet**

☐ **Releases of Information** – Please fill out releases in order for Birch to receive the below provider forms. One provider per page. Please sign for:

- **Current Primary Care Doctor**,
- **Current Mental Health Provider**, &/:
- **Recent Psyc Hospitalization Provider**(**s**)

> *You may* omit *the following if you are filling out releases for current therapists and doctors*

☐ **Psychiatric Evaluation** – Must be within six months of your referral. Please send any other treatment notes you can provide (*treatment plans*, *recent progress notes*, etc.)

☐ **Physical Exam** & **Medication List** – Must be within six months of your referral

Admission Criteria Snapshot

Updated 06/10/2019; condensed and subject to change

Diagnoses Treated

Psychosis diagnoses, most commonly:

✓ **Schizophrenia**
✓ **Bipolar**
✓ **Schizoaffective Disorder**

Coverage

Must draw disability on the merits of a mental illness:

✓ **Medicaid** for mental illness
✓ **Medicaid** with **Medicare** – High disability income over a certain amount will exclude some individuals from receiving coverage
✕ **Private Insurance** – No private insurance will cover our services
✕ **Affordable Care Act** or **ArWorks** – Private insurance through the *ACA* will not cover our services. Individuals who have *ACA* or *ArWorks* coverage should be able to change coverage by contacting DHS if already approved for disability on the merits of a mental illness diagnosis

PASSE Care Coordinator Program

All residents must be enrolled at **Tier 3** to receive residential services. All Medicaid recipients should be eligible for a Tier level determination

Age Limit

Must be 18 years old or older

Exclusionary Criteria

The following is not treated at Birch Tree, even if coinciding with psychosis:

✕ **Antisocial Personality Disorder**
✕ **Borderline Personality Disorder**

Birch Tree cannot accommodate the treatment needs for applicants requiring:

✕ **Skilled Nursing Programs**
✕ **Waiver Services**

REFERRAL FORM

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**Hospitals and Providers can omit this Page if Attaching a Face Sheet with Appropriate Information*

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

A. Identity

Full Name: _____ _____ _____ _____
First | Last | Middle | Other Names

Address: _____ _____ _____ _____
Street | City | State | Zip Code

DoB: _____ SS #: _____ Gender: ____ Race: ____ Education: ____ Marital Status: ____

Phone #: _____ Previous Birch Member? ☐ **No** ☐ **Yes**; what Year(s) _____

B. Diagnosis & Needs

Primary Diagnosis: _____

Secondary & Health Diagnoses: _____

Special Accommodations Needed? ☐ **No** ☐ **Yes**; Please Identify: _____

_____

_____

Is the Client Assigned to a PASSE? ☐ **No/Unsure** ☐ **Yes**; _____ _____ _____
PASSE Program | Tier Level | Care Coordinator & Phone Number

C. Legal Status

Does Client have a Legal Guardian? ☐ **No** ☐ **Yes**; Please Identify below and *Attach a Copy of the Guardianship Order*:

_____ _____ _____ _____
Name | Address | Relationship to Client | Phone

Does the Patient want an Emergency Contact at Birch Tree? ☐ **No** ☐ **Yes**; Same as Guardian ☐ **Yes**; other:

_____ _____ _____ _____
Name | Address | Relationship to Client | Phone

Court Order: ☐ **None** ☐ **45/180 day** ☐ **911** *Attach Copy of Court Order*

Are there any Pending Legal Charges? ☐ **No** ☐ **Yes**; *Attach any Legal Documents*

REFERRAL FINANCIAL INFORMATION

Birch Tree Communities, Inc

BTC is paid through Medicaid. We must review assets before admission in order to verify our members will continue to qualify for Medicaid and HUD housing. Medicare will only sometimes cover our services. We must become payee for members living in our housing. Our members receive the rest of their income after we take out our service charges (usually $630 per month). See our Service Agreement or call for more information.

Client Name: _____

A. Coverage

Medicaid Number: _____ Medicare Number: _____

Does the Client have Another Health Insurance Provider? ☐ **No** ☐ **Yes**; Provider: _____

B. Income

Total Monthly Income before Deductions: $ _____

Sources of Monthly Income (such as SSI, SSDI, VA Benefits) with their Amounts: _____

C. Assets

Does the Client Own or Share Ownership of:

- A Bank Account? ☐ **No** ☐ **Yes**; *Birch may request previous 6 months of bank statements to determine HUD eligibility*
- A Trust Fund or any Other Savings / Bank Account? ☐ **No** ☐ **Yes**
- A Vehicle, House, or Property? ☐ **No** ☐ **Yes**

D. Payee Status

Who is the Current Payee: ☐ **Client** ☐ **Guardian** ☐ **Current / Most Recent Provider** ☐ **Other**;

_____	_____	_____	_____
Name	Address	Relationship to Client	Phone

E. Accommodations

Has the Client Encountered Bed Bugs in Current / Previous Housing? ☐ **No** ☐ **Yes**; Last Encounter: _____ ☐ **Yes**; Currently

---------- **Office Use Only** ----------

Residential Care: ☐ **No** ☐ **Yes**; Starting Address: _____

Monthly Charge: ☐ **$630** ☐ **Other**: $_____ Date Admitted: _____ Payee Change Date: _____ Days Due: _____

Total Charge to Previous Payee: $_____ Collected (Signature when Complete): _____

Additional Notes: _____

_____

Birch Tree Communities, Inc.
PO BOX 1589 BENTON AR 72018
501-345-3344 | WWW.BIRCHTREE.ORG

AUTHORIZATION TO RELEASE INFORMATION

a) I am Authorizing Birch Tree to: ☒**Obtain Information** *and/ or* ☒**Disclose Information**

b) To *and/ or* From: _____
Name of Organization/ Individual

c) For the Purpose of: ☐**Continuity of Care** ☒**Referral** ☐**Individual/ Guardian Request**
☐**Legal** ☐**Other***(specify)*:_____

d) This Authorization Expires: ☒**After 1 Year** *or;* ☐**Less than 1 Year on:**_____

e) Personal Records to be Obtained/ Disclosed:

☒**Psychiatric Evaluation**
☒**Medication Administrations/ MAR**
☒**Mental Health Evaluation**
☒**Current Treatment Plan/Review**
☒**Progress Notes**
☒**Physical/ Vitals/ Lab Work**
☒**Aftercare/ Discharge Summary**
☒**Face Sheet/ Demographic Information**
☒**Tuberculosis Skin Test Results**
☒**Verbal/ Written Communication**
☐**Other***(specify)*:_____

TRANSMISSION Unless otherwise specified, Birch Tree reserves the right to disclose information as permitted by this authorization in any manner that is deemed to be appropriate and consistent with applicable law, including, but not limited to: verbally, in paper format, and/ or electronically.

SENSITIVITY 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.

RE-DISCLOSURE 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.

RIGHT TO DECLINE 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.

RIGHT TO REVOKE I understand that I have the right to revoke my authorization in writing at any time by sending a written notification to Birch Tree Communities at the address listed above.

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

_____ _____ _____
Individual's Printed Name **Date of Birth** **Social Security Number**

_____ _____
Individual *or Guardian* Signature* **Date**

_____ _____
Witness Signature if Needed **Date**

*A Guardian Request must be Accompanied by a Guardianship Letter to Validate Signature Revised: 2/21/19

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