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, COO, 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 PASSEs.

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. Property ownership (this affects HUD eligibility)
6. Bank account info (this affects HUD eligibility)
7. Tiered, and assigned to a PASSE (Only clients assigned to Tier 2 or Tier 3 are eligible for admission.)

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 medication list, a psychiatric evaluation, and some form of treatment history/participation via progress notes

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

- Skilled Nursing Programs
- Waiver Services
- Sex Offender Registration

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

Initial Referral Form

_____ _____ _____ _____
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 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?

_____

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**
- **Copy of Guardianship**
- **History & Physical**
- **Release of Information (make as many copies as needed)**
  - **PLEASE NOTE: one ROI form per provider/family member.**
  - **Include Social Security Administration.**

Birch Tree COMMUNITIES

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

AUTHORIZATION TO RELEASE INFORMATION

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 **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)
□__Other (specify)_____

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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- □ __ Tuberculosis Skin Test Results
- □ __ Verbal/ Written Communication
- □__ Psychotherapy Notes (cannot be combined with another disclosure)
- X__Other (specify) electronic communication

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_____	_____	_____
Guardian Signature	Date	Printed Name
_____	_____	_____
Witness Signature	Date	Printed Name