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Phone (615) 526-1916 | Fax (215) 220-2682| | admissions@projecttransition.com

PRE-ADMISSION PACKET, PROJECT TRANSITION TRADITIONAL IN TENNESSEE

Please review and complete all attached documents to gather the required information needed to support a new Member's admission to Project Transition. We will attempt to gather all clinical information available for the last 2 years, enabling us to have a more detailed clinical picture of the Member and to be able to support the Member with initial goals. **Please have this form and all other documents returned to the Admissions Department at (215) 220-2682 or scan and e-mail to admissions@projecttransition.com**

Below is a list of documentation required prior to admission:

1. Physician recommendation for 24/7 Supportive Housing **(FORM ATTACHED)**
2. Signed Physical — dated no more than 6 months prior to admission **(FORM ATTACHED)**
3. Labs (required if presently taking Clozaril, Depakote, Lithium or Tegretol, dated within 30 days prior to admission)
4. Psychiatric Evaluation (current and any recent)
5. Valid Photo ID
6. Insurance Card
7. Birth Certificate
8. Social Security Card
9. 6 months of Medication List **(FORM ATTACHED)**
10. "About the Member" form **(FORM ATTACHED)**
11. Consent/s **(FORM ATTACHED)**
12. Authorization and Understanding Statement/consent to run a background check **(FORM ATTACHED)**
13. Completed apartment rental application; this is required by the apartment complexes, complete only the areas marked in yellow **(FORM ATTACHED)**

Consents must be fully complete for:

- Any family members or other positive supports
- Payee (if the member received Social Security benefits)
- ICM or other external supports
- Current and any previous treatment provider in the last two years

Documents Required **if** the Member has an income:

- Social security award letter
- Bank account statements
- Pay stubs (if applicable)

If the Member needs help in gathering any of the required documents, please contact us for support.

Thank you,
The Project Transition Admissions Team

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ABOUT THE MEMBER

First Name: _____

Last Name: _____

- Date of Birth: _____
- Social Security Number: _____
- Medicaid County Record Number: _____
- Health Insurance Provider Name _____
  Member ID _____
  RX Bin _____
  PCN _____
  Group # _____
- Permanent Address: _____
  _____
  _____

  This address will be where mail is sent and retrieved. This address must continue be used after admission. The Project Transition program address cannot be used. Members need to maintain their permanent address to maintain benefits.

Circle those below that apply to the member:

• A history of fire setting	YES	NO
• A history of harm to animals	YES	NO
• A diagnosis of an Intellectual Developmental Disability	YES	NO
• Traumatic Brain Injury	YES	NO
• Substance Abuse History	YES	NO
• Current positive drug use	YES	NO
• Past legal charges (felony)	YES	NO
• Pending legal charges	YES	NO

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MEMBER CONTACTS

- Emergency Contact Name #1: _____

  Emergency Contact Address #1: _____
  _____

  Emergency Contact Phone #1: _____

- Emergency Contact Name #2: _____

  Emergency Contact Address #2: _____
  _____

  Emergency Contact Phone #2: _____

- Primary Care Provider Name: _____

  Primary Care Provider Address: _____
  _____

  Primary Care Provider Phone: _____

- Dentist Name: _____

  Dentist Address: _____
  _____

  Dentist Phone Number: _____

- PO Name: _____

  PO Phone Number: _____

  PO E-mail Address: _____

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PHYSICIAN RECOMMENDATION

To Whom It May Concern:

My signature on this document serves as my recommendation that _____ is in
(Printed member name)
need of 24/7 Supportive Housing Level of Care.

Sincerely,

_____ _____
(Treating Medical Doctor Signature) Date

_____
(Treating Medical Doctor Printed Name)

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PHYSICIAN RECOMMENDATION

To Whom It May Concern:

My signature on this document serves as my recommendation that _____ needs
(Printed Member name)

Project Transitions Level 1- Orientation- Independent Living Level of Care.

Sincerely,

_____ _____

(Treating Medical Doctor signature) Date

_____
(Treating Medical Doctor Printed Name)

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PROJECT TRANSITION PHYSICAL EVALUATION FORM

Name: _____ D.O.B. _____
Height: _____ Age: _____
Weight: _____ Blood Pressure/Pulse:_____

Review of Systems/History

Eyes

Loss of Vision	YES	NO	Blurred Vision	YES	NO
Distorted Vision (Halos)	YES	NO	Loss of Side Vision	YES	NO
Double Vision	YES	NO	Mucous Discharge	YES	NO
Redness	YES	NO	Sandy or gritty feeling	YES	NO
Itching	YES	NO	Burning	YES	NO
Foreign body sensation	YES	NO	Excess tearing/watering	YES	NO
Occasional tearing	YES	NO	Glare/light sensitivity	YES	NO
Eye pain or soreness	YES	NO	Sites, Chalazion	YES	NO
Chronic infection of eye or lid	YES	NO	Other	YES	NO

If answered yes to any of the above please explain:
_____
_____
_____

Respiratory

Asthma	YES	NO	Emphysema/COPD	YES	NO
Bronchitis	YES	NO	Chronic Cough	YES	NO
Seasonal Allergies	YES	NO	Tuberculosis	YES	NO
Pneumonia	YES	NO	Shortness of Breath	YES	NO
Smoking History	YES	NO	Other	YES	NO

If answered 'yes' to any of the above please explain:
_____
_____
_____

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Cardiovascular

High Blood Pressure	YES	NO	Low Blood Pressure	YES	NO
Heart Attack	YES	NO	Chest Pain/Angina	YES	NO
Heart Murmur	YES	NO	Congestive Heart Failure	YES	NO
Irregular Heart Beat	YES	NO	Migraines	YES	NO
Slow or Fast Heart Rate	YES	NO	Bleeding Problems	YES	NO
Stroke/TIA's	YES	NO	Other Blood or lymphatic	YES	NO

If answered yes to any of the above please explain:

_____
_____
_____

Systemic

Diabetes	YES	NO	Intestinal/Bowel Problems	YES	NO
Thyroid	YES	NO	Cancer	YES	NO
Kidney Disease	YES	NO	Arthritis	YES	NO
Hepatitis/Yellow Jaundice	YES	NO	Other Musculoskeletal	YES	NO
Convulsions/Seizures	YES	NO	Other Skin Problems	YES	NO
Blackouts	YES	NO	Other Neurological	YES	NO
Hiatal Hernia	YES	NO	Other Eyes, Nose, Throat	YES	NO
Stomach Ulcers	YES	NO	Other Gastrointestinal	YES	NO
HIV/AIDS	YES	NO	Other Genitourinary	YES	NO

If answered yes to any of the above please explain:

_____
_____
_____

List all injuries the member has had:

_____
_____
_____

List all surgeries the member has had in the past:

_____
_____
_____

Review of Drug and Alcohol History

Does the member have a history of substance abuse? YES NO

If yes, please explain including substance/s used, frequency of use and relapse profile:

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_____
_____
_____

Medications

Does the member have any allergies to any Medications (if so please list each medication and type of reaction)?

_____
_____
_____

List all medications the member is currently on:

_____
_____
_____

List medication history of member (physical and psychotropic):

_____
_____
_____

Are you prescribing/recommending any new medication? YES NO

If yes, please list below:

_____
_____
_____

Have you reviewed this member's list of medications? YES NO

Recommendations

Does member present with identified breathing and/or cardiovascular problems

_____
_____
_____

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Are there any physical limitations that would prevent/restrict the member from following a physical fitness regime of:

Moderate aerobic exercise (30 min/day)	YES	NO	Walking	YES	NO
Strength training	YES	NO	Running	YES	NO
Yoga stretching	YES	NO	Karate/Martial Arts	YES	NO
Water aerobics/therapy	YES	NO	Biking	YES	NO
			Other: _____	YES	NO

Are there any nutritional/dietary needs?

_____
_____

What is member's BMI? _____

Is BMI in a healthy range? YES NO If no, what is healthy range? _____

Weight loss recommended? YES NO If yes, what is goal weight? _____

Is member up-to-date with immunizations/tetanus? YES NO

Does member use tobacco regularly? YES NO

Is smoking cessation program recommended? YES NO

Referrals or follow-up appointments:

_____
_____
_____

Other Recommendations:

_____
_____
_____

_____ _____

Signature of Physician Date of Evaluation

_____

Printed Name of Physician

_____

Reviewed by Project Transition Psychiatrist Date

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AUTHORIZATION AND UNDERSTANDING STATEMENT

Name: _____

Social Security Number: _____

Driver's License #: _____

Driver's License State: _____

Date of Birth: _____

Permanent Address: _____
_____
_____

I authorize Project Transition and its designated security agent to contact either orally or in writing any third parties to obtain any information they deem necessary and appropriate in verifying my application. I specifically authorize this company or its designated agent to obtain from any state or local law enforcement agency to include US Military authorities concerning my conduct, including any criminal history record information and motor vehicle reports.

_____ _____

Member Signature Date

_____

Member Name (Print)

_____ _____

Signature of witness who has validated applicants ID Date

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MEMBER MEDICATION LIST

Please complete the following form and list ALL psychiatric and physical medications for the last six months.

- Note, at least **3 days of psychiatric medications** and at least **14 days of physical medications** are need on admission day.

Please also provide any available medication scripts.

Medication	Dosage/Frequency	When Taken	Prior Auth Required?

Presently participating in a Methadone or Suboxone Maintenance Program?

YES, METHADONE **YES, SUBOXONE** **NO**

Member Name (Print):_____

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Consent for Release of Information

I, _____, hereby give my permission to the staff of Project Transition to
(print name)
obtain from _____

(Organization/Name and Title) (Phone #)

_____

(Address) (City) (State) (Zip Code)

the following specific information (please check next to the lines you consent release of):

___Psychiatric Evaluation ___Medical History, including physical examination

___Biopsychosocial Assessment ___ Authorization of Services (Clinical Reviews)

___Treatment Planning ___ Program Status ___ Discharge Planning

___Discharge Summary (from past treatment episodes)

___ Other_____

for the purpose(s) of (please check next to the items purpose):

___Admission planning ___ Permanent Address Verification ___Legal Background Check

___Authorization of Services ___ Benefits Information ___Emergency Contact

___Other_____

- I understand the nature of this authorization. I understand that my authorization shall remain effective until _____ (**date to be no longer than one year**).
- I understand that all information released will be handled confidentially, in compliance with the Federal Privacy Act (PL92-282).
- I understand that I may revoke this authorization (except to the extent that action has been taken in reliance thereon) at any time by verbal or written communication to the releasing agency.
- I have been informed of my right (subject to RULES OF TENNESSEE DEPARTMENT OF HEALTH AND MENTAL RETARDATION CHAPTER 0940-05-06 MINIMUM PROGRAM REQUIREMENTS FOR ALL FACILITIES) to inspect the material to be released.

_____ _____

Member Signature Date

_____ _____

Project Transition Staff/Witness Signature Date

NOTICE TO RECIPIENT OF INFORMATION

This information had been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are protected under the federal regulations on the confidentiality of alcohol and drug abuse patient records (42 CFR Part 2), you are prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. D and A – all QI 8/2016

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_____

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Consent for Release of Information

I, _____, hereby give my permission to the staff of Project Transition to obtain from _____
(print name)

(Organization/Name and Title) (Phone #)

_____

(Address) (City) (State) (Zip Code)

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___Treatment Planning ___ Program Status ___ Discharge Planning

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ITEMS NEEDED ON ADMISSION DAY

The below items are needed for the member on the day of admission. We understand that a member may not have all the necessary items.

Personal Care Items:

- ✓ Twin sheet set, twin mattress cover, pillow, blanket and/or comforter
- ✓ Towels and washcloth
- ✓ Soap, shampoo, personal care items (mouthwash must be alcohol free)
- ✓ Seasonally appropriate clothing (enough for doing laundry 1x per week)
- ✓ Laundry detergent
- ✓ Alarm Clock
- ✓ Plastic Hangers

Personal Identification:

- ✓ Insurance and prescription card
- ✓ Driver's License/State ID
- ✓ Social security card
- ✓ Birth certificate

Records/other Information:

- ✓ Hospital/doctor's records
- ✓ Contact information for physician's and therapists
- ✓ At least **3 days of psychiatric medications** and at least **14 days of physical medications***
- ✓ Emergency contact information: names, phone numbers, addresses

Suggested Items:

- ✓ Radio
- ✓ Television (cable is not provided by Project Transition)
- ✓ Laptop/computer (Internet is not provided by Project Transition)
- ✓ Cell Phone
- ✓ Bicycle
- ✓ Familiar items to make member feel at home such as photos of friends/family/pets

Items <u>NOT</u> permitted:

- ➢ Open flame candles
- ➢ Weapons
- ➢ Drugs or Alcohol
- ➢ Safes to which Project Transition will not have regular access to (key is required to be provided to staff upon admission)

If a member has a question regarding items he/she is permitted to bring, do not hesitate to contact Project Transition Admissions for assistance.

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FAX COVER

To: Project Transition Admissions	From:
Fax: 215-220-2682	Re:
Date:	# of Pages:

Check the items below that are included in this transmission:

_____ Social Security Card
_____ Birth Certificate
_____ Signed Physical
_____ Labs
_____ Psychiatric Evaluation
_____ Insurance Card
_____ SSI Award letter
_____ Authorization and Understanding Statement
_____ Valid Photo ID
_____ Consent/s
_____ Rental Application
_____ Medication List
_____ “About the Member” form
_____ Other (please list below what other items are enclosed)