PROJECT TRANSITION
Hope and Healing Through Community

2031 Antioch Pike, Antioch TN 37013
Phone (615) 526-1916 | Fax (215) 220-2682| | admissions@projecttransition.com

Below is a list of documentation required prior to admission:

1. Signed Physical — **dated within the last 6 months** **(FORM ATTACHED)**
2. Psychiatric Evaluation **dated within the last 6 months** (current and any recent)
3. Identifying Documents
    a. Valid Photo ID and
    b. Insurance Card and
    c. Birth Certificate and
    d. Social Security Card
4. MD Letter **(FORM ATTACHED)**
    a. This MUST be signed by an MD
5. Medication List **(FORM ATTACHED)**
6. "About the Member" form **(FORM ATTACHED)**
7. Consent/s **(FORMS ATTACHED)**
8. Authorization and Understanding Statement/consent to run a background check **(FORM ATTACHED)**
9. Completed apartment rental application; this is required by the apartment complex's, complete only the areas marked in yellow **(FORM ATTACHED)**
10. Labs (required if presently taking Clozaril, Depakote, Lithium or Tegretol, dated within 30 days prior to admission)

Consents must be fully complete for:

- Any family members or other positive supports with whom we may release information/speak with
- Parole or probation officer
- Rep Payee (if the member received Social Security benefits)
- ICM or other external supports
- Current and any previous treatment provider in the last two years

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

Thank you!

Emma Doyle, Lauren Bocklet, Benji Holmes, Ryan Kinsch, and Jessica Walker
The Project Transition Admissions Team

PROJECT TRANSITION
Hope and Healing Through Community

2031 Antioch Pike, Antioch TN 37013
Phone (615) 526-1916 | Fax (215) 220-2682| | admissions@projecttransition.com

ABOUT THE MEMBER

First Name: _____ Last Name: _____

Member Phone: _____Date of Birth: _____

Social Security Number: _____ Medicaid County Record Number: _____

Health Insurance Provider Name _____

Member ID _____ RX Bin _____

PCN _____ Group # _____

Member Permanent Address:
_____

This address is where 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 history of aggressive/violent behavior to property or people 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
- Sexually challenging behavior YES NO
- IQ of <61 YES NO

Emergency Contact Info

Name: _____ Relationship: _____

Contact Phone: _____

Address: _____

Name: _____ Relationship: _____

Contact Phone: _____

Address: _____

PROJECT TRANSITION
Hope and Healing Through Community

2031 Antioch Pike, Antioch TN 37013
Phone (615) 526-1916 | Fax (215) 220-2682| | admissions@projecttransition.com

Medical Contacts

Primary Care Provider Name: _____ Provider Phone: _____

Provider Address: _____

Dentist Name: _____ Dentist Phone Number: _____

Dentist Address: _____

Rep Payee for Social Security (if not applicable, write N/A)

Rep Payee Name (if applicable):_____Rep Payee Phone: _____

Legal Contacts

Probation or Parole Officer Name (Circle if probation or parole):_____

PO Phone Number: _____ PO E-mail Address: _____

County: _____

ICM Contact

Name: _____ Company Name: _____

ICM Phone: _____ ICM Email: _____

Family Contact

1. Name: _____ Relationship: _____

   Phone: _____

   Address: _____

2. Name: _____ Relationship: _____

   Phone: _____

   Address: _____

PROJECT TRANSITION
Hope and Healing Through Community

2031 Antioch Pike, Antioch TN 37013
Phone (615) 526-1916 | Fax (215) 220-2682| | admissions@projecttransition.com

CONSENT FOR RELEASE OF INFORMATION

I, _____, hereby give my permission to the staff of Project Transition to obtain from:

_____

(Organization, Name & 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) and the Pennsylvania Mental Health Procedure Act.
- I also 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 Section 710. I I I .3 of the Pennsylvania Mental Health Procedures Act and subject to the Pennsylvania Drug and Alcohol Abuse Control Act) to inspect the material to be released.

_____ _____

Member Signature affirms they have been given a copy of this consent Date

_____ _____

Witness Signature affirms members has been given a copy of this consent Date

NOTICE RECIPIENT OF INFORMATION

This information had been disclosed you from records the confidentiality of which may be protected 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 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 2. A general authorization for the release 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 drug abuse patient. D and A-all QI 8/2016

Last revised: April 2018

PROJECT TRANSITION
Hope and Healing Through Community

2031 Antioch Pike, Antioch TN 37013
Phone (615) 526-1916 | Fax (215) 220-2682| | admissions@projecttransition.com

CONSENT FOR RELEASE OF INFORMATION

I, _____, hereby give my permission to the staff of Project Transition to obtain from:

_____

(Organization, Name & 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) and the Pennsylvania Mental Health Procedure Act.
- I also 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 Section 710. I I I .3 of the Pennsylvania Mental Health Procedures Act and subject to the Pennsylvania Drug and Alcohol Abuse Control Act) to inspect the material to be released.

_____ _____

Member Signature affirms they have been given a copy of this consent Date

_____ _____

Witness Signature affirms members has been given a copy of this consent Date

NOTICE RECIPIENT OF INFORMATION

This information had been disclosed you from records the confidentiality of which may be protected 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 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 2. A general authorization for the release 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 drug abuse patient. D and A-all QI 8/2016

PROJECT TRANSITION
Hope and Healing Through Community

2031 Antioch Pike, Antioch TN 37013
Phone (615) 526-1916 | Fax (215) 220-2682| | admissions@projecttransition.com

CONSENT FOR RELEASE OF INFORMATION

I, _____, hereby give my permission to the staff of Project Transition to obtain from:

_____

(Organization, Name & 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) and the Pennsylvania Mental Health Procedure Act.
- I also 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 Section 710. I I I .3 of the Pennsylvania Mental Health Procedures Act and subject to the Pennsylvania Drug and Alcohol Abuse Control Act) to inspect the material to be released.

_____ _____

Member Signature affirms they have been given a copy of this consent Date

_____ _____

Witness Signature affirms members has been given a copy of this consent Date

NOTICE RECIPIENT OF INFORMATION

This information had been disclosed you from records the confidentiality of which may be protected 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 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 2. A general authorization for the release 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 drug abuse patient. D and A-all QI 8/2016

PROJECT TRANSITION
Hope and Healing Through Community

2031 Antioch Pike, Antioch TN 37013
Phone (615) 526-1916 | Fax (215) 220-2682| | admissions@projecttransition.com

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

PROJECT TRANSITION
Hope and Healing Through Community

2031 Antioch Pike, Antioch TN 37013
Phone (615) 526-1916 | Fax (215) 220-2682| | admissions@projecttransition.com

MEMBER MEDICATION LIST

Member Name (Print):_____

Please complete the following form and list ALL currently prescribed psychiatric and physical medications

Medication	Dosage/Frequency	When Taken	Prior Auth Required?
Presently participating in a Methadone or Suboxone Maintenance Program? **YES, METHADONE** **YES, SUBOXONE** **NO**			

PROJECT TRANSITION
Hope and Healing Through Community

2031 Antioch Pike | Nashville, TN 37211
Phone (615) 526-1916 | Fax (215) 220-2682| | admissions@projecttransition.com

PHYSICIAN RECOMMENDATION (24/7)

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)

Last revised: April 2018

QI 8/2016

PROJECT TRANSITION
Hope and Healing Through Community

2031 Antioch Pike | Nashville, TN 37211
Phone (615) 526-1916 | Fax (215) 220-2682| | admissions@projecttransition.com

PHYSICIAN RECOMMENDATION (Level 1)

To Whom It May Concern:

My signature on this document serves as my recommendation that _____ is in
(Printed member name)

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

Sincerely,

_____ _____ (Treating Medical Doctor Signature) Date

_____ (Treating Medical Doctor Printed Name)