

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
3. Identifying Documents
 - a. Valid Photo ID and
 - b. Insurance Card and
 - c. Birth Certificate and
 - d. Social Security Card
4. Medication List (FORM ATTACHED)
5. "About the Member" form (FORM ATTACHED)
6. Consent/s (FORMS ATTACHED)
7. Authorization and Understanding Statement/consent to run a background check (FORM ATTACHED)
8. Completed apartment rental application; this is required by the apartment complexes, complete only the areas marked in yellow (FORM ATTACHED)
9. 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 receives 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. You can reach our entire team by e-mailing us at admissions@projecttransition.com or calling 215-997-9959 and asking for Admissions.

Thank you!

Benji Holmes

Victoria Ernst

The Project Transition Admissions Team

Patient Information

First Name: _____ Last Name: _____

Member Phone: _____ Date of Birth: _____

Social Security Number: _____

Health Insurance Provider Name: _____

Member ID: _____ RX Bin: _____

PCN: _____ Group #: _____

Member Permanent Address: _____

For members who are homeless and do not have a permanent address that is viable to use, please let us know and we will provide an alternative.

This address is 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.

Check boxes below that apply to the patient

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 (including Autism spectrum or Asperger's Syndrome) YES NO

Traumatic Brain Injury YES NO

Currently on probation YES NO

Currently on parole YES NO

Currently incarcerated YES NO

A history of sexually challenging behavior YES NO

Emergency Contact Information

1. Name: _____ Relationship: _____

Contact Phone: _____

Address: _____

2. Name: _____ Relationship: _____

Contact Phone: _____

Address: _____

Referring Provider

Referring Facility/Agency:

Current Level of Care (*Acute inpatient, Sub Acute, Rehab, DHS, OP, other, etc.*):

Referring Agency Contact Name:

Referring Agency Contact Title:

Referring Contact Phone:

Referring Contact Fax:

Referring Contact E-mail:

Who to Contact to Start Preadmission Process:

Phone:

E-mail:

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:

Relationship:

Legal Contacts

Probation or Parole Officer Name

PO Phone Number:

PO E-mail Address:

County:

Case Manager Contact

Name:	Company Name:
ICM Phone:	ICM Email:

Family and Other Supports Contact Information

1. Name:	Relationship:
Phone:	
Address:	

2. Name:	Relationship:
Phone:	
Address:	

Pre-Admission Packet

Authorization and Understanding Statement



Name: _____ Social Security Number: _____

Driver's License Number: _____ 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 _____



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
(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

Pre-Admission Packet

Physician Recommendation (Level 1)

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)

Pre-Admission Packet

Physician Recommendation (24/7 Supportive Housing)

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)

Project Transition Treatment Informed Consent

I, _____, hereby acknowledge that I have been informed of and have an understanding of the services that I am to receive at Project Transition.

I, _____, hereby consent to being admitted to Project Transition, where I will receive:

Telehealth Assessment and/or Telehealth Session

Member Signature

Date

Project Transition Staff Signature

Date

Rental Application for Residents and Occupants

Each co-applicant and each occupant 18 years old and over must submit a separate application.
Spouses may submit a single application.



Date when filled out: _____

ABOUT YOU Full name (exactly as on driver's license or govt. ID card) _____

Your street address (as shown on your driver's license or government ID card): _____

Driver's license # and state: _____
OR govt. photo ID card #: _____

Former last names (maiden and married): _____

Your Social Security #: _____

Birthdate: _____ Height: _____ Weight: _____

Sex: _____ Eye color: _____

Marital Status: single married divorced widowed separated

Are you a U.S. citizen? Yes No Do you or any occupant smoke? yes no

Will you or any occupant have an animal? yes no

Kind, weight, breed, age: _____

Current home address (where you now live): _____

City/State/Zip: _____

Home/cell phone: (_____) _____ Current rent: \$ _____ N/A

Email address: _____

Name of apartment where you now live: _____ N/A

Current owner or manager's name: _____ N/A

Their phone: _____ N/A Date moved in: _____ N/A

Why are you leaving your current residence? _____ N/A

Your previous home address: _____ N/A

City/State/Zip: _____ N/A

Apartment name: _____ N/A

Name of above owner or manager: _____ N/A

Their phone: _____ N/A Previous monthly rent: \$ _____ N/A

Date you moved in: _____ N/A Date you moved out: _____ N/A

YOUR WORK Present employer: _____ N/A

Address: _____ N/A

City/State/Zip: _____ N/A

Work phone: (_____) _____ N/A

Position: _____ N/A

Your gross annual income is over: \$ _____ N/A

Date you began this job: _____ N/A

Supervisor's name and phone: _____ N/A

Previous employer: _____ N/A

Address: _____ N/A

City/State/Zip: _____ N/A

Work phone: (_____) _____ N/A

Position: _____ N/A

Gross annual income was over: \$ _____ N/A

Dates you began and ended this job: _____ N/A

Previous supervisor's name and phone: _____ N/A

YOUR CREDIT HISTORY Your bank's name, city, state: _____ N/A

List major credit cards: _____ N/A

Other non-work income you want considered. Please explain: _____ N/A

Past credit problems you want to explain. (Use separate page.) _____ N/A

WHY YOU APPLIED HERE Were you referred? Yes No.

If yes, by whom: _____ N/A

Name of locator or rental agency: _____ N/A

Name of individual locator or agent: _____ N/A

Name of friend or other person: _____ N/A

Did you find us on your own? Yes No If yes, fill in information below:

On the Internet Stopped by Newspaper (name): _____ N/A

Rental publication: _____ N/A

Other: _____ N/A

YOUR RENTAL/CRIMINAL HISTORY Check only if applicable. Have you, your spouse, or any occupant listed in this Application ever: been evicted or asked to move out? moved out of a dwelling before the end of the lease term without the owner's consent? declared bankruptcy? been sued for rent? been sued for property damage? been charged, detained, or arrested for a felony, misdemeanor involving a controlled substance, violence to another person or destruction of property, or a sex crime that was resolved by conviction, probation, deferred adjudication, court ordered community supervision, or pretrial diversion? been charged, detained, or arrested for a felony, misdemeanor involving a controlled substance, violence to another person or destruction of property, or a sex crime that has not been resolved by any method? Please indicate below the year, location and type of each felony, misdemeanor involving a controlled substance, violence to another person or destruction of property, or sex crime other than those resolved by dismissal or acquittal. We may need to discuss more facts before making a decision. You represent the answer is "no" to any item not checked above. _____

YOUR SPOUSE Full name: _____ N/A

Former last names (maiden and married): _____ N/A

Spouse's Social Security #: _____ N/A

Driver's license # and state: _____ N/A

OR govt. photo ID card #: _____ N/A

Birthdate: _____ N/A Height: _____ N/A Weight: _____ N/A

Sex: _____ N/A Eye color: _____ N/A

Are you a U.S. citizen? Yes No

Present employer: _____ N/A

Address: _____ N/A

City/State/Zip: _____ N/A

Work phone: (_____) _____ N/A

Position: _____ N/A

Date began job: _____ N/A Gross annual income is over: \$ _____ N/A

Supervisor's name and phone: _____ N/A

OTHER OCCUPANTS Names of all persons under 18 and other adults who will occupy the unit without signing the lease. Continue on separate page if more than three.

Name: _____ N/A Relationship: _____ N/A

Sex: _____ N/A DL or govt. ID card # and state: _____ N/A

Birthdate: _____ N/A Social Security #: _____ N/A

Name: _____ N/A Relationship: _____ N/A

Sex: _____ N/A DL or govt. ID card # and state: _____ N/A

Birthdate: _____ N/A Social Security #: _____ N/A

Name: _____ N/A Relationship: _____ N/A

Sex: _____ N/A DL or govt. ID card # and state: _____ N/A

Birthdate: _____ N/A Social Security #: _____ N/A

YOUR VEHICLES List all vehicles owned or operated by you, your spouse, or any occupants (including cars, trucks, motorcycles, trailers, etc.). Continue on separate page if more than three.

Make and color of vehicle: _____

Year: _____ License #: _____ State: _____

Make and color of vehicle: _____

Year: _____ License #: _____ State: _____

Make and color of vehicle: _____

Year: _____ License #: _____ State: _____

EMERGENCY Emergency contact person over 18, who will not be living with you:

Name: _____ N/A

Address: _____ N/A

City/State/Zip: _____ N/A

Work phone: (_____) _____ N/A Home phone: (_____) _____ N/A

Relationship: _____ N/A

AUTHORIZATION I or we authorize (owner's name) _____

FRBH Woodbridge LLC

to obtain reports from any consumer or criminal record reporting agencies before, during, and after tenancy on matters relating to a lease by the above owner to me and to verify, by all available means, the information in this application, including criminal background information, income history and other information reported by employer(s) to any state employment security agency. Work history information may be used only for this Rental Application. Authority to obtain work history information expires 365 days from the date of this Application.

Applicant's signature _____

Spouse's signature _____

Applicant must also sign on the next page of this Application.

Contemplated Lease Contract Information

To be filled in only if the Lease Contract is not signed by resident(s) at time of application for rental.

The National Apartment Association Lease Contract to be used must be the latest version published by the association unless an earlier version is initialed by resident(s) and attached to this Application. The blanks in the Lease Contract will contain the following information:

- Names of all residents who will sign Lease Contract
Name of Owner/Lessor FRBH Woodbridge LLC
Property name and type of dwelling Woodbridge Apartments
Complete street address 231 Bridgeway Circle
City/State/Zip Nashville, TN 37211
Names of all other occupants not signing Lease Contract
Total number of residents and occupants
Beginning date and ending date of Lease Contract
Total security deposit \$; Animal deposit \$ 0.00
Other fees \$
Total monthly rent for dwelling unit \$
Rent to be paid at (check one) [X] on-site manager's office or [] at
Prorated rent for: [X] first month or [] second month \$
Monthly rental due date
Returned-check charge \$ 35.00
Utilities paid by owner (check all that apply): [] electricity, [] gas, [] water, [] wastewater, [] trash, [] cable TV, [] master TV antenna;
You are (check one): [X] required to purchase personal liability insurance or [] not required to purchase personal liability insurance;
Agreed reletting charge \$
Special provisions regarding parking, storage, etc.: (see attached page if necessary): Parking policy: First come first serve basis.

Application Agreement

- 1. Lease Contract Information. The Lease Contract contemplated by the parties is attached or, if no Lease Contract is attached, the Lease Contract will be the current Lease Contract noted above. Special information and conditions must be explicitly noted on an attached Lease Contract or in the Contemplated Lease Contract Information above.
2. Application Fee (nonrefundable). You have delivered to our representative an application fee in the amount indicated below, and this payment partially defrays the cost of administrative paperwork. It's nonrefundable.
3. Application Deposit (may or may not be refundable). In addition to any application fee, you have delivered to our representative an application deposit in the amount indicated below. The application deposit is not a security deposit. However, it will be credited toward the required security deposit when the Lease Contract has been signed by all parties; OR it will be refunded under paragraph 10 if you are not approved; OR it will be retained by us as liquidated damages if you fail to sign or attempt to withdraw under paragraph 6 or 7.
4. Approval When Lease Contract Is Signed in Advance. If you and all co-applicants have already signed the Lease Contract when we approve the Application, our representative will notify you (or one of you if there are co-applicants) of our approval, sign the Lease Contract, and then credit the application deposit of all applicants toward the required security deposit.
5. Approval When Lease Contract Isn't Yet Signed. If you and all co-applicants have not signed the Lease Contract when we approve the Application, our representative will notify you (or one of you if there are co-applicants) of the approval, sign the Lease Contract when you and all co-applicants have signed, and then credit the application deposit of all applicants toward the required security deposit.
6. If You Fail to Sign Lease Contract After Approval. Unless we authorize otherwise in writing, you and all co-applicants must sign the Lease Contract within 3 days after we give you our approval in person or by telephone or within 5 days after we mail you our approval. If you or any co-applicant fails to sign as required, we may keep the application deposit as liquidated damages, and terminate all further obligations under this Agreement.
7. If You Withdraw Before Approval. You and any co-applicant may not withdraw your application or the application deposit. If you or any co-applicant withdraws an Application or notifies us that you've changed your mind about renting the dwelling unit, we'll be entitled to retain all application deposits as liquidated damages, and the parties will then have no further obligation to each other.
8. Completed Application. An Application will not be considered "completed" and will not be processed until all of the following have been provided to us (unless checked): [X] a separate Application has been fully filled out and signed by you and each co-applicant; [X] an application fee has been paid to us; [] an application deposit has been paid to us. If no item is checked, all are necessary for the Application to be considered completed.
9. Non-approval. We will notify you whether you've been approved within 10 days after the date we receive a completed Application. Your Application will be considered "disapproved" if we fail to notify you of your approval within 10 days after we have received a completed Application. Notification may be in person or by mail or telephone unless you have requested that notification be by mail. You must not assume approval until you receive actual notice of approval. The 10-day time period may be changed only by separate written agreement.
10. Refund after Non-approval. If you or any co-applicant is disapproved or deemed disapproved under paragraph 9, we'll refund all application deposits within 30 days of such disapproval. Refund checks may be made payable to all co-applicants and mailed to one applicant.
11. Extension of Deadlines. If the deadline for signing, approving, or re-funding under paragraphs 6, 9, or 10 falls on a Saturday, Sunday, or a state or federal holiday, the deadline will be extended to the end of the next day.
12. Notice to or from Co-applicants. Any notice we give you or your co-applicant is considered notice to all co-applicants; and any notice from you or your co-applicant is considered notice from all co-applicants.
13. Keys or Access Devices. We'll furnish keys and/or access devices only after: (1) all parties have signed the contemplated Lease Contract and other rental documents referred to in the Lease Contract; and (2) all applicable rents and security deposits have been paid in full.
14. Receipt. Application fee (nonrefundable): \$ 50.00
Application deposit (may or may not be refundable): \$
Other move-in fees (may or may not be refundable): \$ 150.00
Total of above application fee and application deposit: \$
Total amount of money we've received to this date: \$
15. Signature. Our representative's signature is consent only to this Application Agreement. It does not bind us to accept applicant or to sign the proposed Lease Contract.

Acknowledgment. You declare that all your statements on the first page of this Application are true and complete. You authorize us to verify same through any means. If you fail to answer any question or give false information, we may reject the application, retain all application fees and deposits as liquidated damages for our time and expense, and terminate your right of occupancy. Giving false information is a serious criminal offense. In lawsuits relating to the application or Lease Contract, the prevailing party may recover all attorney's fees and litigation costs from the losing party. We may at any time furnish information to consumer reporting agencies and other rental housing owners regarding your performance of your legal obligations, including both favorable and unfavorable information about your compliance with the Lease Contract, the rules, and financial obligations.

If you're seriously ill or injured, what doctor may we notify? (We're not responsible for providing medical information to or calling doctors or emergency personnel.)
Doctor's name: Doctor's phone: ()
Important medical information about you in an emergency:

Applicant's Signature: Date:
Signature of Spouse: Date:
Signature of Owner's Representative: Date:

FOR OFFICE USE ONLY
1. Apt. name or dwelling address (street, city) FRBH Woodbridge LLC
2. Person accepting application:
3. Person processing application:
4. Date that applicant or co-applicant was notified by [] telephone, [] letter, or [] in person of [] acceptance or [] nonacceptance:
5. Name of person(s) who were notified (at least one applicant must be notified if multiple applicants):
6. Name of owner's representative who notified above person(s):

Physical Evaluation Form

Please answer every question on this form and be sure to sign the last page.

First Name: _____ Last Name: _____ Date of Birth: _____

Height: _____ Weight: _____ Blood Pressure/Pulse: _____

Review of Systems/History

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

If answered yes to any of the above please explain:

Respiratory

Asthma	<input type="checkbox"/> YES <input type="checkbox"/> NO	Chronic Cough	<input type="checkbox"/> YES <input type="checkbox"/> NO
Bronchitis	<input type="checkbox"/> YES <input type="checkbox"/> NO	Tuberculosis	<input type="checkbox"/> YES <input type="checkbox"/> NO
Seasonal Allergies	<input type="checkbox"/> YES <input type="checkbox"/> NO	Shortness of Breath	<input type="checkbox"/> YES <input type="checkbox"/> NO
Pneumonia	<input type="checkbox"/> YES <input type="checkbox"/> NO	Other	<input type="checkbox"/> YES <input type="checkbox"/> NO
Smoking History	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Emphysema/COPD	<input type="checkbox"/> YES <input type="checkbox"/> NO		

If answered yes to any of the above please explain:

Physical Evaluation Form

Review of Systems/History

High Blood Pressure	<input type="checkbox"/> YES <input type="checkbox"/> NO	Low Blood Pressure	<input type="checkbox"/> YES <input type="checkbox"/> NO
Heart Attack	<input type="checkbox"/> YES <input type="checkbox"/> NO	Chest Pain/Angina	<input type="checkbox"/> YES <input type="checkbox"/> NO
Heart Murmur	<input type="checkbox"/> YES <input type="checkbox"/> NO	Congestive Heart Failure	<input type="checkbox"/> YES <input type="checkbox"/> NO
Irregular Heart Beat	<input type="checkbox"/> YES <input type="checkbox"/> NO	Migraines	<input type="checkbox"/> YES <input type="checkbox"/> NO
Slow or Fast Heart Rate	<input type="checkbox"/> YES <input type="checkbox"/> NO	Bleeding Problems	<input type="checkbox"/> YES <input type="checkbox"/> NO
Stroke/TIAs	<input type="checkbox"/> YES <input type="checkbox"/> NO	Other Blood or lymphatic	<input type="checkbox"/> YES <input type="checkbox"/> NO

If answered yes to any of the above please explain:

Respiratory

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

If answered yes to any of the above please explain:

If answered yes to any of the above please explain:

If answered yes to any of the above please explain:

Physical Evaluation Form

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:

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

Does this patient have any mobility issues that would prevent them from living successfully in an apartment and participating in a residential treatment program?

Physical Evaluation Form

Recommendations

Does member present with identified breathing and/or cardiovascular problems

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

Moderate aerobic exercise (30 min/day)	<input type="checkbox"/> YES <input type="checkbox"/> NO	Running	<input type="checkbox"/> YES <input type="checkbox"/> NO
Strength training	<input type="checkbox"/> YES <input type="checkbox"/> NO	Karate/Martial Arts	<input type="checkbox"/> YES <input type="checkbox"/> NO
Yoga stretching	<input type="checkbox"/> YES <input type="checkbox"/> NO	Biking	<input type="checkbox"/> YES <input type="checkbox"/> NO
Water aerobics/therapy	<input type="checkbox"/> YES <input type="checkbox"/> NO	Other:	<input type="checkbox"/> YES <input type="checkbox"/> NO
Walking	<input type="checkbox"/> YES <input type="checkbox"/> 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:

Physical Examination

General: _____

Vital Signs: _____

HEENT: _____

Signature of Physician: _____ Date of Evaluation: _____

Printed Name of Physician: _____

Reviewed by Project Transition Psychiatrist: _____ Date: _____

ADVANCE DIRECTIVE FOR HEALTH CARE*
(Tennessee)

Instructions: Parts 1 and 2 may be used together or independently. Please mark out/void any unused part(s). Part 5, Block A or Block B must be completed for all uses.

I, _____, hereby give these advance instructions on how I want to be treated by my doctors and other health care providers when I can no longer make those treatment decisions myself.

Part 1 Agent: I want the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: _____ Relation: _____ Home Phone: _____ Work Phone: _____
Address: _____ Mobile Phone: _____ Other Phone: _____

Alternate Agent: If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: _____ Relation: _____ Home Phone: _____ Work Phone: _____
Address: _____ Mobile Phone: _____ Other Phone: _____

My agent is also my personal representative for purposes of federal and state privacy laws, including HIPAA.

When Effective (mark one): I give my agent permission to make health care decisions for me at any time, even if I have capacity to make decisions for myself. I do not give such permission (this form applies only when I no longer have capacity).

Part 2 Indicate Your Wishes for Quality of Life: By marking “yes” below, I have indicated conditions I would be willing to live with if given adequate comfort care and pain management. By marking “no” below, I have indicated conditions I would not be willing to live with (that to me would create an **unacceptable** quality of life).

<input type="checkbox"/> Yes <input type="checkbox"/> No	Permanent Unconscious Condition: I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
<input type="checkbox"/> Yes <input type="checkbox"/> No	Permanent Confusion: I become unable to remember, understand, or make decisions. I do not recognize loved ones or cannot have a clear conversation with them.
<input type="checkbox"/> Yes <input type="checkbox"/> No	Dependent in all Activities of Daily Living: I am no longer able to talk or communicate clearly or move by myself. I depend on others for feeding, bathing, dressing, and walking. Rehabilitation or any other restorative treatment will not help.
<input type="checkbox"/> Yes <input type="checkbox"/> No	End-Stage Illnesses: I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that no longer responds to treatment; chronic and/or damaged heart and lungs, where oxygen is needed most of the time and activities are limited due to the feeling of suffocation.

Indicate Your Wishes for Treatment: If my quality of life becomes unacceptable to me (as indicated by one or more of the conditions marked “no” above) and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. By marking “yes” below, I have indicated treatment I want. By marking “no” below, I have indicated treatment I **do not want**.

<input type="checkbox"/> Yes <input type="checkbox"/> No	CPR (Cardiopulmonary Resuscitation): To make the heart beat again and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.
<input type="checkbox"/> Yes <input type="checkbox"/> No	Life Support / Other Artificial Support: Continuous use of breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys, and other organs to continue to work.
<input type="checkbox"/> Yes <input type="checkbox"/> No	Treatment of New Conditions: Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness.
<input type="checkbox"/> Yes <input type="checkbox"/> No	Tube feeding/IV fluids: Use of tubes to deliver food and water to a patient’s stomach or use of IV fluids into a vein, which would include artificially delivered nutrition and hydration.

Part 3 Other instructions, such as hospice care, burial arrangements, etc.: _____

(Attach additional pages if necessary)

Part 4 Organ donation: Upon my death, I wish to make the following anatomical gift for purposes of transplantation, research, and/or education (mark one):
 Any organ/tissue My entire body Only the following organs/tissues: _____

 No organ/tissue donation

SIGNATURE

Part 5 Your signature must **either** be witnessed by two competent adults (“Block A”) **or** by a notary public (“Block B”).

Signature: _____ Date: _____
(Patient)

Block A Neither witness may be the person you appointed as your agent or alternate, and at least one of the witnesses must be someone who is not related to you or entitled to any part of your estate.

Witnesses:

- 1. I am a competent adult who is not named as the agent. I witnessed the patient’s signature on this form. _____
Signature of witness number 1
- 2. I am a competent adult who is not named as the agent. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient’s estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient’s signature on this form. _____
Signature of witness number 2

Block B You may choose to have your signature witnessed by a notary public instead of the witnesses described in Block A.

STATE OF TENNESSEE
COUNTY OF _____

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person who signed as the “patient.” The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

My commission expires: _____
Signature of Notary Public

WHAT TO DO WITH THIS ADVANCE DIRECTIVE: (1) provide a copy to your physician(s); (2) keep a copy in your personal files where it is accessible to others; (3) tell your closest relatives and friends what is in the document; (4) provide a copy to the person(s) you named as your health care agent.

* This form replaces the old forms for durable power of attorney for health care, living will, appointment of agent, and advance care plan, and eliminates the need for any of those documents.