Pre-Admission Packet

PROJECT TRANSITION
Hope and Healing Through Community

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 complexs, 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

William Patton

The Project Transition Admissions Team

Pre-Admission Packet

PROJECT TRANSITION
Hope and Healing Through Community

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:

PROJECT TRANSITION
Hope and Healing Through Community

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:

PROJECT TRANSITION
Hope and Healing Through Community

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

PROJECT TRANSITION
Hope and Healing Through Community

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

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
(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

PROJECT TRANSITION
Hope and Healing Through Community

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)

PROJECT TRANSITION
Hope and Healing Through Community

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:

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 *(bedrooms and baths)* **Woodbridge Apartments** ;
- Complete street address **231 Bridgeway Circle** City/State/Zip **Nashville, TN 37211** ;
- Names of all other occupants not signing Lease Contract *(persons under age 18, relatives, friends, etc.)* _____ ;
- 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)* ☒ on-site manager's office or ❑ at _____ ;
- Prorated rent for: ☒ first month or ❑ second month $ _____ ;
- Monthly rental due date _____ ;
- Returned-check charge $ **35.00** ;
- *(Check one):* ❑ furnished or ☒ unfurnished;
- Utilities paid by owner *(check all that apply):* ❑ electricity, ❑ gas, ❑ water, ❑ wastewater, ❑ trash, ❑ cable TV, ❑ master TV antenna;
- You are *(check one):* ☒ 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):* ☒ a separate Application has been fully filled out and signed by you and each co-applicant; ☒ 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 refunding 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** Unit # or type: _____
2. Person accepting application: _____ Phone: (_____) _____
3. Person processing application: _____ Phone: (_____) _____
4. Date that applicant or co-applicant was notified by ❑ telephone, ❑ letter, or ❑ in person of ❑ acceptance or ❑ nonacceptance: _____
(Deadline for applicant and all co-applicants to sign lease is three days after notification of acceptance in person or by telephone, five days if by mail.)
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

PROJECT TRANSITION
Hope and Healing Through Community

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:

HEENT

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	Burning	☐ YES	☐ NO
Itching	☐ YES	☐ NO	Excess tearing/watering	☐ YES	☐ NO
Foreign body sensation	☐ YES	☐ NO	Glare/light sensitivity	☐ YES	☐ NO
Occasional tearing	☐ YES	☐ NO	Other HEENT	☐ YES	☐ NO
Eye pain or soreness	☐ YES	☐ NO			
Chronic infection of eye or lid	☐ YES	☐ NO			

If answered yes to any of the above please explain:

Respiratory

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

If answered yes to any of the above please explain:

Cardiac

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

If answered yes to any of the above please explain:

Physical Evaluation Form

PROJECT TRANSITION
Hope and Healing Through Community

Cardiac

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	Bleeding Problems	☐ YES ☐ NO
Slow or Fast Heart Rate	☐ YES ☐ NO	Other Blood or lymphatic	☐ YES ☐ NO
Stroke/TIA's	☐ YES ☐ NO	Other Cardiac	☐ YES ☐ NO

If answered yes to any of the above please explain:

Endocrine

Diabetes	☐ YES ☐ NO	Kidney Disease	☐ YES ☐ NO
Thyroid	☐ YES ☐ NO	Hepatitis/Yellow Jaundice	☐ YES ☐ NO

If answered yes to any of the above please explain:

Gastrointestinal

Hiatal Hernia	☐ YES ☐ NO	Other Gastrointestinal	☐ YES ☐ NO
Stomach Ulcers	☐ YES ☐ NO	Other Genitourinary	☐ YES ☐ NO
Intestinal / Bowel Problems	☐ YES ☐ NO		

If answered yes to any of the above please explain:

Neurological

Convulsions / Seizures	☐ YES ☐ NO	Blackouts	☐ YES ☐ NO
Migraines	☐ YES ☐ NO	Other Neurological	☐ YES ☐ NO

If answered yes to any of the above please explain:

Other

Skin Problems	☐ YES ☐ NO	Cancer	☐ YES ☐ NO
HIV / AIDS	☐ YES ☐ NO	Musculoskeletal	☐ YES ☐ NO
STD / STI	☐ YES ☐ NO		

If answered yes to any of the above please explain:

Physical Evaluation Form

PROJECT TRANSITION
Hope and Healing Through Community

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?

Last lab level drawn if applicable

Is the member on MAT? (Suboxone, Bunavail, Vivitrol, etc.) ☐ YES ☐ NO
If yes, list the name of the medication, the name and phone number of the provider prescribing MAT

Physical Evaluation Form

PROJECT TRANSITION
Hope and Healing Through Community

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)	☐ YES ☐ NO	Running	☐ YES ☐ NO
Strength training	☐ YES ☐ NO	Karate/Martial Arts	☐ YES ☐ NO
Yoga stretching	☐ YES ☐ NO	Biking	☐ YES ☐ NO
Water aerobics/therapy	☐ YES ☐ NO	Other:	☐ YES ☐ NO
Walking	☐ 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:

Physical Examination

General Appearance _____

HEENT Findings _____

Pupils Equal ☐ YES ☐ NO

Hearing _____

Lymph Nodes _____

Heart Murmurs (Auscultation standing, auscultation supine, and ± Valsalva maneuver) _____

Pre-Admission Packet

Member Medication List

PROJECT TRANSITION
Hope and Healing Through Community

Member Name:

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

Physical Evaluation Form

PROJECT TRANSITION
Hope and Healing Through Community

Physical Examination

Lungs _____

Abdomen _____

Skin _____

Rashes _____

Musculoskeletal _____

Gait _____

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 I **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).

☐ Yes ☐ No	**Permanent Unconscious Condition:** I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
☐ Yes ☐ 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.
☐ Yes ☐ 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.
☐ Yes ☐ 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**.

☐ Yes ☐ 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.
☐ Yes ☐ 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.
☐ Yes ☐ 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.
☐ Yes ☐ 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.

PLEASE SIGN ON PAGE 2

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.

DECLARATION FOR MENTAL HEALTH TREATMENT

TDMHSAS

Tennessee Department of Mental Health and Substance Abuse Services

developed this form based on
Tennessee Code Annotated, Title 33, Chapter 6, Part 10.

The DMHT in Tennessee

What Is a DMHT?

For those of us with mental illness, our commitment to recovery includes making a plan for keeping well. Many of us use the Wellness Recovery Action Plan (WRAP®) by Mary Ellen Copeland to list what we need to stay well, to identify our triggers, and to create a crisis plan. But there are times when, despite our commitment to recovery, we get worse. Perhaps something big happens in our lives and it's just more than we can cope with. Sometimes our symptoms get the better of us.

Tennessee has created a legal document that can help. It's called a Declaration for Mental Health Treatment (DMHT). And when we find ourselves in a crisis, it can give us peace of mind. The DMHT is a legal document where we can write down our wishes in case of a mental health crisis. We can write down mental health treatments and medications that are okay with us and any that are not okay with us. We can write down what it looks like when we are in a mental health crisis and need help. Some people like to write down which hospitals they prefer and which mental health agencies they prefer, too.

Here's how to fill out your DMHT:

1. Read the entire DMHT form first.

2. Some sections of the DMHT form ask you to choose at least one option. In those sections, you will have to pick one of the options.

3. When you write down your wishes on the form, be as specific as you can.

4. There is a place at the bottom of each page where you need to put your initials and the date.

5. When you are ready to sign, get two adults to be your witnesses.

6. Pick two people who already know you. You cannot pick anyone who works for a mental health facility. That's against the rules for the DMHT because the people who wrote the DMHT rules want to make sure you aren't pressured to write down anything you don't want to.

7. Before you sign in front of the witnesses that you picked, tell them about what you wrote in your DMHT.

8. Be sure to talk with the friends and family members of your choice about what you wrote in your DMHT so they can be there for you in the way you want.

Important Legal Information

The Tennessee Department of Mental Health and Substance Abuse Services developed this form based on Tennessee Code Annotated, Title 33, Chapter 6, Part 10.

Tennessee Code Annotated, Title 33, Chapter 6, Part 10, gives the right to individuals, 16 years of age and older, to be involved in decisions about their mental health treatment. The law also recognizes that, at times, some individuals are unable to make treatment decisions. A "Declaration for Mental Health Treatment" allows people receiving services to plan ahead; it may also assist service providers in giving appropriate treatment.

This "Declaration for Mental Health Treatment" form describes what a service participant wants to occur when receiving mental health treatment. It describes mental health services that a service participant might consider, the conditions under which a declaration may be acted upon, and directions on how a service participant can revoke/cancel a declaration.

For example, completion of a "Declaration for Mental Health Treatment" form allows a service participant to state:

- Conditions or symptoms that might cause the declaration to be acted upon;
- Medications you are willing to take and medications you are not willing to take;
- Specific instructions for or against electroconvulsive or other convulsive treatment;
- Mental health facilities and mental health providers which you prefer;
- Treatments or actions which you will allow or those which you refuse to permit; and
- Any other matter pertaining to your mental health treatment which you wish to make known.

You must sign the form in front of two (2) competent adult witnesses (18 years or older) who know you. You must discuss the contents of this form with the witnesses prior to them signing it. It is important to note that restrictions exist on who may witness the declaration. The following parties may <u>not</u> act as witnesses:

- o The service participant's mental health service provider;
- o An employee of the service participant's mental health service provider;
- o The operator of a mental health facility; or
- o An employee of a mental health facility.

This declaration may include consent to, or refusal to, permit mental health treatment and other instructions and information for mental health service providers.

Declaration for Mental Health Treatment for:

_____

(Print Your Full Name)

This DMHT says what my wishes are for mental health treatment when I am in a mental health crisis and can't make decisions for myself.

I understand that sometimes I cannot make decisions about mental health treatment because of the symptoms of my mental illness. This is when I am in a mental health crisis.

Here are my symptoms when I am having a mental health crisis:

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Initials____Date_____

This DMHT gives me the right to say what medications I am okay with, how I feel about ECT (electroconvulsive therapy), and which psychiatric hospital I prefer (for up to 15 days).

Medication *(Psychoactive and other Medications)*

If I am in a mental health crisis and cannot make my own mental health treatment decisions, here are my wishes about medication:

You must check one:

☐ I do not have a preference about medications.

☐ I do not want the following medications:

Name of medication: _____

Reason I don't want it: _____
_____
_____
_____

Name of medication: _____

Reason I don't want it: _____
_____
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_____

Name of medication: _____

Reason I don't want it: _____
_____
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_____

Name of medication: _____

Reason I don't want it: _____
_____
_____
_____

Initials____Date_____

These medications have worked for me in the past:

Name of medication: _____

How it worked for me: _____
_____
_____
_____

Name of medication: _____

How it worked for me: _____
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Name of medication: _____

How it worked for me: _____
_____
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Additional medication concerns:

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Initials____Date_____

Going to the Hospital
*(Admission to and Remaining in a Hospital for Mental Health Treatment)**

If I am in a mental health crisis and not able to make decisions, these are my preferences about going to the hospital:

You must check one:

☐ I do not have a preference about being admitted to a hospital for mental health treatment.

☐ I am okay with being admitted to a hospital for mental health treatment. I consent.

☐ I do not want to go voluntarily to a hospital for mental health treatment. I do not consent.

If I have to go to a hospital for mental health treatment, then I want the following to happen:

You must check one:

☐ I will remain voluntarily in the hospital for mental health treatment. I consent.

☐ I do not want to remain voluntarily in the hospital for mental health treatment. I do not consent.

Additional hospitalization concerns:

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*Psychiatric hospital authorization in a DMHT is limited to 15 days.

Initials____Date_____

Mental Health Services from Other Places

Tennessee has places other than the hospital where you can receive help for your mental illness. These are places like a Crisis Stabilization Unit (CSU), a respite facility, and others.

If I am in a mental health crisis and not able to make decisions, these are my preferences about receiving mental health services from places other than a hospital:

You must check one:

☐ I do not have a preference about receiving mental health services from places other than a hospital.

☐ I am okay with receiving mental health services from places other than a hospital. I consent.

☐ I do not want to receive mental health services from places other than a hospital. I do not consent.

Additional concerns about mental health services from other places:

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Initials____Date__________

Specific Mental Health Agencies, Hospitals, and Other Places for Treatment

If I am in a mental health crisis and not able to make decisions, these are my preferences about certain mental health agencies, specific hospitals, and other places for mental health treatment:

Check all that apply:

- ☐ I do not have a preference about any specific mental health agencies, specific hospitals, and other places for mental health treatment.
- ☐ I do not prefer the following specific mental health agencies, specific hospitals, and other places for mental health treatment.
- ☐ I do prefer the following specific mental health agencies, specific hospitals, and other places for mental health treatment.

Names of hospitals, mental health agencies, and other places for mental health treatment that I...	
DO NOT CONSENT TO:	**PREFER:**

Additional concerns about specific mental health agencies, hospitals and other places for treatment:

_____
_____
_____
_____
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_____
_____
_____
_____.

Initials____Date_____

ECT (Electroconvulsive Therapy) and Other Convulsive Therapies*

If I am in a mental health crisis and not able to make decisions, these are my preferences about receiving ECT (electroconvulsive therapy) and other convulsive therapies:

You must check one:

☐ I do not have a preference about receiving ECT (electroconvulsive therapy) and other convulsive therapies.

☐ I do not want to receive ECT (electroconvulsive therapy) or other convulsive therapies. I do not consent.

☐ I am okay with ECT (electroconvulsive therapy). If I have any conditions, I have written them below.

☐ I am okay with other convulsive therapies. If I have any conditions, I have written them below.

**Your decision to consent to electroconvulsive therapy may be limited if you are considered to be a child under certain provisions of the law. Your decision to consent to electroconvulsive therapy may be limited if you are a child in the state's custody under certain provisions of the law.*

Initials____Date_____

Other Preferences

If I am in a mental health crisis and not able to make decisions, here are some additional things I prefer:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Here are the people I want to be called if I am in a mental health crisis:

Name _____

Home Phone (with area code) _____

Work Phone (with area code) _____

Cell Phone (with area code) _____

Name _____

Home Phone (with area code) _____

Work Phone (with area code) _____

Cell Phone (with area code) _____

Name _____

Home Phone (with area code) _____

Work Phone (with area code) _____

Cell Phone (with area code) _____

Initials____Date_____

My Affirmation

I am sixteen (16) years of age or older. I am capable of making informed mental health treatment decisions. I make this "Declaration for Mental Health Treatment" to be followed if I become unable to make informed mental health treatment decisions. The determination that I am unable to make an informed decision about my mental health treatment must be made by (1) a court in a conservatorship or guardianship preceding, or (2) two examining physicians, or (3) a physician with expertise in psychiatry and a doctoral level psychologist with health service provider designation.

I know that I may cancel this DMHT, in whole or in part, at any time, by word or in writing, when I am able to make informed treatment decisions.

This declaration will expire two years from the day it is signed by me and two witnesses or a shorter period specified by this date: _____/_____/_____ or until revoked.

My Name (printed) _____

My Signature _____ Date _____

Address _____

City, State, ZIP _____

Phone (with area code) _____

Date of Birth _____

Initials____Date_____

Affirmation of the First Witness

I affirm that _____ is personally known to me; that he or she signed this "Declaration for Mental Health Treatment" in my presence; that he or she talked to me about the document and its contents and the reasons for preparing and wanting the document to be effective. He or she appears to be able to make informed mental health treatment decisions and is not under duress, fraud or undue influence. The declaration was not signed on the premises of a mental health service provider.

I affirm that I am an adult and that I am not:

The service participant's mental health services provider
An employee of the service participant's mental health services provider
The operator of a mental health facility
An employee of a mental health facility.

You must check one:

I am a relative by blood, marriage, or adoption.*

☐ Yes ☐ No

You must check one:

I am likely to be entitled to a portion of this person's estate in the event of his/her death.**

☐ Yes ☐ No

First Witness Name (print) _____

First Witness Signature_____ Date_____

Address _____

Phone (with area code) _____

*Only one of the two witnesses can be a relative by blood, marriage, or adoption.
**Only one of the two witnesses can be a person likely to benefit from the death of the person completing the declaration.

Initials____Date_____

Affirmation of the Second Witness

I affirm that _____ is personally known to me; that he or she signed this "Declaration for Mental Health Treatment" in my presence; that he or she talked to me about the document and its contents and the reasons for preparing and wanting the document to be effective. He or she appears to be able to make informed mental health treatment decisions and is not under duress, fraud or undue influence. The declaration was not signed on the premises of a mental health service provider.

I affirm that I am an adult and that I am not:

The service participant's mental health services provider
An employee of the service participant's mental health services provider
The operator of a mental health facility
An employee of a mental health facility.

You must check one:

I am a relative by blood, marriage, or adoption.*

☐ Yes ☐ No

You must check one:

I am likely to be entitled to a portion of this person's estate in the event of his/her death.**

☐ Yes ☐ No

Second Witness Name (print) _____

Second Witness Signature_____ Date_____

Address _____

Phone (with area code) _____

*Only one of the two witnesses can be a relative by blood, marriage, or adoption.
**Only one of the two witnesses can be a person likely to benefit from the death of the person completing the declaration.

Initials____Date_____

For additional information about the
Declaration for Mental Health Treatment, contact the
TDMHSAS Office of Consumer Affairs and Peer Support Services
at 1-800-560-5767
or by email to
OCA.Tdmhsas@tn.gov

For questions about information on our Website,
Contact the Publication Editor c/o the
Tennessee Department of Mental Health and Substance Abuse Services
Office of Communications
at (615) 253-4812
or by email to OC.Tdmhsas@tn.gov

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