

## 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](mailto:admissions@projecttransition.com) or calling 215-997-9959 and asking for Admissions.

Thank you!

*Benji Holmes*

*William Patton*

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 |
TNadmissions@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.)



Date when filled out: \_\_\_\_\_

APPLICANT INFORMATION			
Full Name (Exactly as it appears on Driver's License or Govt. ID card)			
Former Name (if applicable)		Gender (Optional)	
Birthdate	Social Security #	Driver's License #	State
Government Photo ID card #		Type	
Home Phone Number	Cell Phone Number	Work Phone Number	
Email Address			
Marital Status: <input type="checkbox"/> single <input type="checkbox"/> married <input type="checkbox"/> widowed <input type="checkbox"/> separated		Do you or any occupant smoke? <input type="checkbox"/> yes <input type="checkbox"/> no	
I am applying for the apartment located at: _____			
Is there another co-applicant? <input type="checkbox"/> yes <input type="checkbox"/> no			
Co-applicant Name			
Email			
Co-applicant Name			
Email			
Co-applicant Name			
Email			
Co-applicant Name			
Email			
Co-applicant Name			
Email			
OTHER OCCUPANTS			
Full Name		Relationship	
Date of Birth	Social Security #	Driver's License #	State
Government Photo ID card #		Type	
Full Name		Relationship	
Date of Birth	Social Security #	Driver's License #	State
Government Photo ID card #		Type	
Full Name		Relationship	
Date of Birth	Social Security #	Driver's License #	State
Government Photo ID card #		Type	
Full Name		Relationship	
Date of Birth	Social Security #	Driver's License #	State
Government Photo ID card #		Type	
Full Name		Relationship	
Date of Birth	Social Security #	Driver's License #	State
Government Photo ID card #		Type	
Full Name		Relationship	
Date of Birth	Social Security #	Driver's License #	State
Government Photo ID card #		Type	

**RESIDENCY INFORMATION**

Current Home Address (where you live now)

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Do you q rent or q own? \_\_\_\_\_  
Dates: \_\_\_\_\_ \$ \_\_\_\_\_  
From \_\_\_\_\_ To \_\_\_\_\_ Monthly Payment

Apartment Name \_\_\_\_\_

Landlord/Lender Name \_\_\_\_\_ Phone \_\_\_\_\_

Reason for Leaving \_\_\_\_\_

(The following is only applicable if at current address for less than 6 months.)

Previous Home Address

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Do you q rent or q own? \_\_\_\_\_  
Dates: \_\_\_\_\_ \$ \_\_\_\_\_  
From \_\_\_\_\_ To \_\_\_\_\_ Monthly Payment

Apartment Name \_\_\_\_\_

Landlord/Lender Name \_\_\_\_\_ Phone \_\_\_\_\_

Reason for Leaving \_\_\_\_\_

**EMPLOYMENT INFORMATION**

Present Employer \_\_\_\_\_ Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Work Phone \_\_\_\_\_  
Dates: \_\_\_\_\_ \$ \_\_\_\_\_  
From \_\_\_\_\_ To \_\_\_\_\_ Gross Monthly Income

Position \_\_\_\_\_

Supervisor Name \_\_\_\_\_ Phone \_\_\_\_\_

(The following is only applicable if at current employer for less than 6 months.)

Previous Employer \_\_\_\_\_ Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Work Phone \_\_\_\_\_  
Dates: \_\_\_\_\_ \$ \_\_\_\_\_  
From \_\_\_\_\_ To \_\_\_\_\_ Gross Monthly Income

Position \_\_\_\_\_

Supervisor Name \_\_\_\_\_ Phone \_\_\_\_\_

**ADDITIONAL INCOME**

(Income must be verified to be considered)

Type \_\_\_\_\_ Source \_\_\_\_\_ \$ \_\_\_\_\_  
Gross Monthly Amount  
Type \_\_\_\_\_ Source \_\_\_\_\_ \$ \_\_\_\_\_  
Gross Monthly Amount

**CREDIT HISTORY (if applicable)**

If applicable, please explain any past credit problem:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**RENTAL/CRIMINAL HISTORY**

(Check only if applicable)

Have you or any occupant listed in this Application ever:

- q been evicted or asked to move out?
  - q moved out of a dwelling before the end of the lease term without the owner's consent?
  - q declared bankruptcy?
  - q been sued for rent?
  - q been sued for property damage?
  - q been convicted (or received an alternative form of adjudication equivalent to conviction) of a felony, misdemeanor involving a controlled substance, violence to another person or destruction of property, or a sex crime?
- Please indicate the year, location and type of each felony, misdemeanor involving a controlled substance, violence to another person or destruction of property, or a 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.*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**REFERRAL INFORMATION**

How did you find us?

- q Online search. Website address: \_\_\_\_\_
- q Referral from a person. Name: \_\_\_\_\_
- q Social Media. Which one? \_\_\_\_\_
- q Other \_\_\_\_\_

**EMERGENCY CONTACT**

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

Name _____		Relationship _____	
Address _____		City _____	
State _____	Zip Code _____	Home Phone # _____	Cell Phone # _____
Work Phone # _____		Email Address _____	

**VEHICLE INFORMATION (if applicable)**

List all vehicles owned or operated by you or any occupants (including cars, trucks, motorcycles, trailers, etc.).

Make _____	Model _____	Color _____
Year _____	License Plate # _____	State _____
Make _____	Model _____	Color _____
Year _____	License Plate # _____	State _____
Make _____	Model _____	Color _____
Year _____	License Plate # _____	State _____
Make _____	Model _____	Color _____
Year _____	License Plate # _____	State _____

**PET INFORMATION (if applicable)**

You may not have any animal in your unit without management's prior authorization in writing. If we allow your requested animal, you must sign a separate animal addendum, which may require additional deposits, rents, fees or other charges.

Name _____	Type _____	Breed _____
Gender _____	Weight _____	Color _____
Age _____	Assistance Animal Status: q yes q no	
Name _____	Type _____	Breed _____
Gender _____	Weight _____	Color _____
Age _____	Assistance Animal Status: q yes q no	

**APPLICATION AGREEMENT**

The following Application Agreement will be signed by you and all co-applicants prior to signing a Lease Contract. While some of the information below may not yet apply to your situation, there are some provisions that may become applicable prior to signing a Lease Contract. In order to continue with this application, you'll need to review the Application Agreement carefully and acknowledge that you accept its terms.

1. **Lease Contract Information.** The Lease Contract contemplated by the parties will be the current Lease Contract. Special information and conditions must be explicitly noted on the Lease Contract.
2. **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.
3. **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.
4. **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.*
5. **If You Withdraw Before Approval.** *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.*
6. **Approval/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.
7. **Refund after Non-Approval.** If you or any co-applicant is disapproved or deemed disapproved under Paragraph 6, 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.
8. **Extension of Deadlines.** If the deadline for signing, approving, or refunding under paragraphs 4, 6, or 7 falls on a Saturday, Sunday, or a state or federal holiday, the deadline will be extended to the end of the next business day.

**APPLICATION AGREEMENT (CONTINUED)**

**9. Keys or Access Devices.** We'll furnish keys and/or access devices only after: (1) all parties have signed the Lease Contract and other rental documents; and (2) all applicable rents and security deposits have been paid in full.

**10. Application Submission.** Submission of a rental application does not guarantee approval or acceptance. It does not bind us to accept the applicant or to sign a Lease Contract.

**DISCLOSURES**

**1. Application Fee (Non-Refundable).** You agree to pay to our representative the non-refundable application fee in the amount indicated in paragraph 3. **Payment of the application fee does not guarantee that your application will be accepted.** The application fee partially defrays the cost of administrative paperwork. **It is non-refundable.**

**2. Application Deposit (may or may not be refundable).** In addition to any application fee(s), you agree to pay to our representative an application deposit in the amount indicated in paragraph 3. *The application deposit is not a security deposit.* The application deposit 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 7 of the Application Agreement if your application is not approved; OR, it will be retained by us as liquidated damages if you fail to sign or attempt to withdraw under paragraphs 4 or 5 of the Application Agreement.

**3. Fees Due. Your Rental Application will not be processed until we receive your completed Rental Application (and the completed Rental Application of all co-applicants, if applicable) and the following fees:**

- 1. Application fee (non-refundable): \$ 50.00
- 2. Application deposit (may or may not be refundable): \$ \_\_\_\_\_

**4. Completed Application.** Your Rental Application for Residents and Occupants will not be considered "completed" and will not be processed until we receive the following documentation and fees:

- 1. Your completed Rental Application;
- 2. Completed Rental Applications for each co-applicant (if applicable);
- 3. Application fees for all applicants;
- 4. Application deposit for the Unit.

**5. 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.

**AUTHORIZATION AND ACKNOWLEDGMENT**

**AUTHORIZATION**

I authorize Lion Willow Apartments, LLC

(name of owner/agent) 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.

**Payment Authorization**

I authorize Lion Willow Apartments, LLC

(name of owner/agent) to collect payment of the application fee and application deposit in the amounts specified under paragraph 3 of the Disclosures.

**Non-Sufficient Funds and Dishonored Payments.**

If a check from an applicant is returned to us by a bank or other entity for any reason, if any credit card or debit card payment from applicant to us is rejected, and if we are unable, through no fault of our own or our bank, to successfully process any ACH debit, credit card, or debit card transaction, then:

- (i) Applicant shall pay to us the NSF Charge; and
- (ii) We reserve the right to refer the matter for criminal prosecution

**ACKNOWLEDGMENT**

You declare that all your statements in this Application are true and complete. You authorize us to verify the same through any means. If you fail to answer any question(s) 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.

\_\_\_\_\_  
**Applicant's Signature**

\_\_\_\_\_  
**Date**

**FOR OFFICE USE ONLY**

\_\_\_\_\_  
**Apt. name or dwelling address (street, city)**

\_\_\_\_\_  
**Unit # or type**

\_\_\_\_\_  
**Person accepting application**

\_\_\_\_\_  
**Phone**

\_\_\_\_\_  
**Person processing application**

\_\_\_\_\_  
**Phone**

Applicant or Co-applicant was notified by q **telephone** q **letter** q **email**, or q **in person** of q **acceptance** or q **non-acceptance** on \_\_\_\_\_.

(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.)

Name of person(s) who were notified (at least one applicant must be notified if multiple applicants):

\_\_\_\_\_  
Name(s)

\_\_\_\_\_  
Name of owner's representative who notified above person(s)

**ADDITIONAL COMMENTS**

**\$200 Application fee is nonrefundable.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



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  
 Distorted Vision (Halos)  YES  NO  
 Double Vision  YES  NO  
 Redness  YES  NO  
 Itching  YES  NO  
 Foreign body sensation  YES  NO  
 Occasional tearing  YES  NO  
 Eye pain or soreness  YES  NO  
 Chronic infection of eye or lid  YES  NO

Blurred Vision  YES  NO  
 Loss of Side Vision  YES  NO  
 Mucous Discharge  YES  NO  
 Burning  YES  NO  
 Excess tearing/watering  YES  NO  
 Glare/light sensitivity  YES  NO  
 Other HEENT  YES  NO

If answered yes to any of the above please explain:

## Respiratory

Asthma  YES  NO  
 Bronchitis  YES  NO  
 Seasonal Allergies  YES  NO  
 Pneumonia  YES  NO  
 Smoking History  YES  NO  
 Emphysema/COPD  YES  NO

Chronic Cough  YES  NO  
 Tuberculosis  YES  NO  
 Shortness of Breath  YES  NO  
 Other Respiratory  YES  NO

If answered yes to any of the above please explain:

## Cardiac

High Blood Pressure  YES  NO  
 Heart Attack  YES  NO  
 Heart Murmur  YES  NO  
 Irregular Heart Beat  YES  NO  
 Slow or Fast Heart Rate  YES  NO  
 Stroke/TIA's  YES  NO  
 Low Blood Pressure  YES  NO

Chest Pain / Angina  YES  NO  
 Congestive Heart Failure  YES  NO  
 Bleeding Problems  YES  NO  
 Other Blood or lymphatic  YES  NO  
 Other Cardiac  YES  NO

If answered yes to any of the above please explain:

# Physical Evaluation Form

## Endocrine

Diabetes  YES  NO  
Thyroid  YES  NO

Kidney Disease  YES  NO  
Hepatitis/Yellow Jaundice  YES  NO

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

---

---

---

## Gastrointestinal

Hiatal Hernia  YES  NO  
Stomach Ulcers  YES  NO  
Intestinal / Bowel Problems  YES  NO

Other Gastrointestinal  YES  NO  
Other Genitourinary  YES  NO

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

---

---

---

---

## Neurological

Convulsions / Seizures  YES  NO  
Migraines  YES  NO

Blackouts  YES  NO  
Other Neurological  YES  NO

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

---

---

---

---

## Other

Skin Problems  YES  NO  
HIV / AIDS  YES  NO  
STD / STI  YES  NO

Cancer  YES  NO  
Musculoskeletal  YES  NO

If answered yes to any of the above please explain:

---

## 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

---



## 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 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



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 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).

<input type="checkbox"/> <input type="checkbox"/> Yes No	<b>Permanent Unconscious Condition:</b> I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
<input type="checkbox"/> <input type="checkbox"/> Yes No	<b>Permanent Confusion:</b> 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"/> <input type="checkbox"/> Yes No	<b>Dependent in all Activities of Daily Living:</b> 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"/> <input type="checkbox"/> Yes No	<b>End-Stage Illnesses:</b> 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"/> <input type="checkbox"/> Yes No	<b>CPR (Cardiopulmonary Resuscitation):</b> 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"/> <input type="checkbox"/> Yes No	<b>Life Support / Other Artificial Support:</b> 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"/> <input type="checkbox"/> Yes No	<b>Treatment of New Conditions:</b> Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness.
<input type="checkbox"/> <input type="checkbox"/> Yes No	<b>Tube feeding/IV fluids:</b> 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.

# Declaration for Mental Health Treatment



**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 not 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.





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: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name of medication: \_\_\_\_\_

Reason I don't want it: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Name of medication: \_\_\_\_\_

How it worked for me: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Additional medication concerns:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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:**

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

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

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.

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

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

---

---

---

---

---

---

---

---

---

---

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 proceeding, 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) \_\_\_\_\_

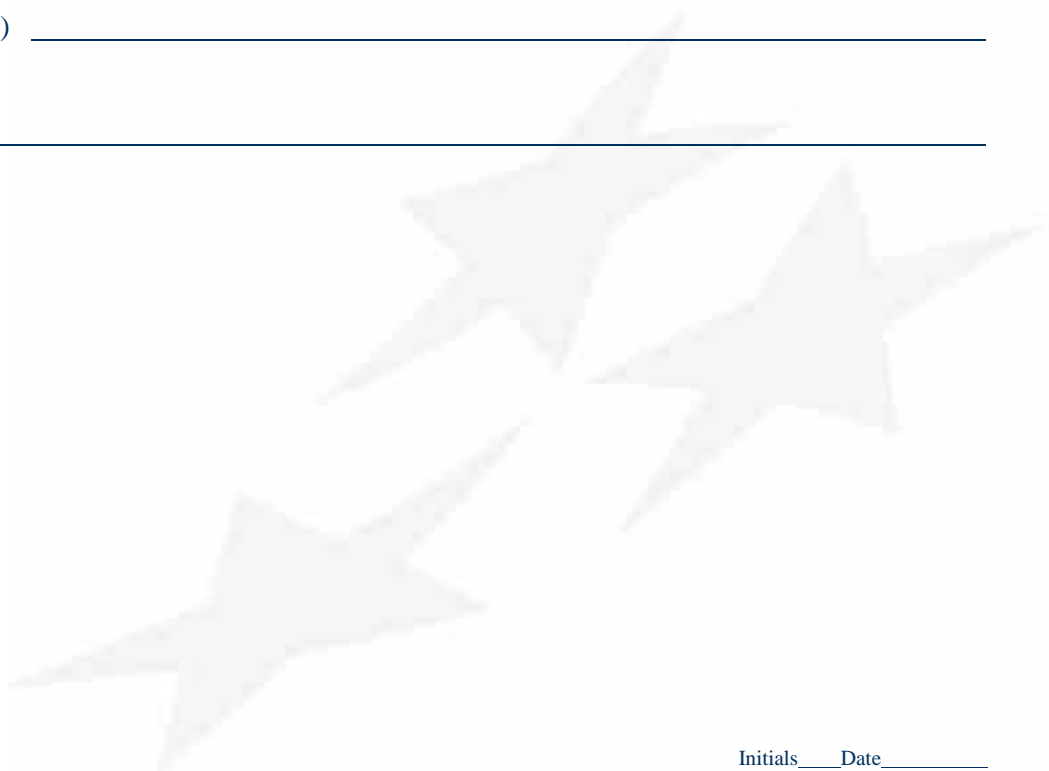
My Signature \_\_\_\_\_ Date \_\_\_\_\_

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



Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS), Authorization No. 339535, 5,000 copies, online and print publication, May 2013, at a cost of \$0.67 per copy.

The Tennessee Department of Mental Health and Substance Abuse Services is committed to the principles of equal opportunity, equal access and affirmative action. Contact the TDMHSAS EEO/AA Coordinator at (615) 532-6580, Office of Human Resources; the Title VI Coordinator at (615) 532-6510; or the ADA Coordinator at (615) 532-6700 for further information. Persons with hearing impairments should contact the department by email at OC.Tdmhsas@tn.gov