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 TNadmissions@projecttransition.com or calling 865-309-5910 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:

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

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

8904 Cross Park Drive Ste B Knoxville, TN 37923
Phone (865) 309-5910 | 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

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 myrecommendation 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 myrecommendation 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

APPLICATION FOR RESIDENCE

Amount due at move in $_____Rental Amount_____Move in date _____
Unit Type_____Apt. #_____Building #_____Lease Term _____

First Name_____Middle Name_____Last Name_____

Date of Birth_____Social Security Number_____Male_____Female_____

Driver's License Number_____State_____ Single_____Married_____Other_____

Home Phone_____Work Phone_____Cell Phone_____

Email Address_____U.S. Citizen _ ☐ _(If unchecked, additional forms are required)

PRESENT ADDRESS

Street Address_____
City_____State_____Zip Code_____
Community Name/Landlord_____Phone Number_____
At this Address: From_____To_____Monthly Rent $_____

PREVIOUS ADDRESS (if less than 3 years at present address)

Street Address_____
City_____State_____Zip Code_____
Community Name/Landlord_____Phone Number_____
At this Address: From_____To_____Monthly Rent $_____
Have you ever been evicted?_____Where_____Why_____
Have you ever broken a lease?_____Where_____Why _____

EMPLOYMENT

Applicant Employer_____ Phone Number_____
Address_____City_____State_____Zip Code_____
Position_____Supervisor_____
Employed here from_____To_____Monthly Gross Salary$_____

VEHICLE INFORMATION

Make_____Model_____Year_____Color_____Lic. No._____State_____
Make_____Model_____Year_____Color_____Lic. No._____State _____

PERSONS TO OCCUPY APARTMENT

Name_____Relationship_____Social Security #_____D/O/B_____
Name_____Relationship_____Social Security #_____D/O/B_____
Name_____Relationship_____Social Security #_____D/O/B_____
Name_____Relationship_____Social Security #_____D/O/B_____
Name_____Relationship_____Social Security #_____D/O/B_____

PETS

Do you have a pet?_YES or_NO(check one)
If yes, How Many?_____Kind(s) of Pet_____Breed/Weight(s)_____

EMERGENCY CONTACT – Please fill out in its entirety

Name_____Relationship_____
Address_____City_____State_____Zip_____
Phone_____Email Address _____

ADDITIONAL INFORMATION

Have you ever been arrested and/or convicted of any misdemeanor or felony or do you have knowledge of anyone who will be occupying the apartment ever being arrested and/or convicted of any misdemeanor or felony?_____YES or_____NO (check one)
If yes, Who?_____When?_____Type of arrest/conviction _____
Have you ever filed bankruptcy or are you presently involved in an active bankruptcy case?_____YES or_____NO (check one)
If yes, when was the bankruptcy filed? _____
Doyoucurrentlyhave asecurityfreezeplaced on yourcreditinformation? _____
Areyou, or anyone who will be occupying the apartment home, a smoker? _____
Howdid youhear aboutourcommunity? _____

The applicant hereby authorizes Brookside Properties Inc./ Brookside Agent to conduct a credit check that includes, but does not limit to, obtaining a credit report and interviewing the applicant's references and previous landlords. The applicant hereby consents to the credit check process and authorizes any individual listed in this application to speak with Brookside Properties Inc./Brookside Agent regarding the applicants present or previous credit performance. Applicant further release any and all individuals who provide information to Brookside Properties Inc./Brookside Agent from any and all claims which the applicant may have resulting from information provided to Brookside Properties Inc. / Brookside Agent. The applicant also authorizes the release of information based upon reliance of either photocopies or facsimiles of the authorization. The undersigned applicant certifies that the above information is true and correct and hereby authorizes verification of same. Any false information in the application shall result in immediate denial of application and or termination of any lease resulting from acceptance of this application. If accepted as a resident, this application is to become a part of the lease file. All information provided will be kept in confidence.

ApplicationFee(non-refundable) $_____ Date rec. _____ Payment Type Check / Credit / Certified Funds Document #_____received or waived
AdministrationFee: $_____ Date rec. _____ PaymentTypeCheck/Credit/CertifiedFunds Document#_____received or waived

If foranyreasonthemanagementdeniesthisapplication,this Administrationfeewill be refunded. Oncethisapplicationis approvedthisfeeisnon-refundable. AdministrationFeeis hereby acknowledged as a non-refundable fee. We are an equal opportunity housing provider. We do not discriminate on the basis of race, color, sex, national origin, religion, handicap, familial status (presence of children under age of 18,) marital status orage.

Applicant's Signature_____ Date _____

Office Use Only: Application Taken By_____Date Received_____Approved or Rejected By_____Date _____

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:

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:

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

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

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

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

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

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

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

☐ ☐ 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:

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

_____

_____

_____

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:

_____

_____

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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:

*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:

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:

_____

_____

_____

_____

_____

_____

_____

_____

_____.

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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