Form: Adam and Amanda Program Application

Adam and Amanda Program Application
ORCA House and C.H. Everett Clinic
Signature Health, Inc.

Basic Data:

Patient Name: _____

Current address: _____

Previous address: _____

DOB: _____/____/_____ **Social Security #:** _____

County of Residence: _____

Gender Identity: _____ **Pronouns:** _____

Ethnicity (check all that apply):

□ Caucasian □ African American

□ Hispanic □ Native American

□ Asian American □ Other

Marital status:

□ Married □ Never Married

□ Widowed □ Separated

□ Divorced □ Domestic Partners

Previous living arrangement:

_____

Is previous living arrangement an option after discharge from Class 1 facility?
☐ Y ☐ N

Previous residential services: ☐ Y ☐ N **If yes, describe:**

_____

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Support Persons – Please list support persons involved in client's care and can be involved in treatment and planning for discharge as needed. We recommend support persons complete our Signature Health release form which can be found on our website:

Name: _____ Relationship: _____

Phone #: _____

Describe support/involvement that can be provided:

_____

Name: _____ Relationship: _____

Phone #: _____

Describe support/involvement that can be provided:

_____

Name: _____ Relationship: _____

Phone #: _____

Describe support/involvement that can be provided:

_____

<u>Psychiatric Hospitalization Data</u>

Recent hospitalization date: _____

Name of hospital: _____

Number of hospitalizations in the last year and dates:

_____

Date of most recent psychiatric assessment: _____

Anticipated discharge date: _____

# of days hospitalized in the past month: _____

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Identify suicidal ideations, attempts, and non-suicidal self-harming behaviors:

_____

Current Diagnosis – DSM-5-TR

Diagnosis 1: _____

Date diagnosed: _____

Diagnosed by whom (name/credentials): _____

Agency or hospital diagnosed at: _____

Diagnosis 2: _____

Date diagnosed: _____

Diagnosed by whom (name/credentials): _____

Agency or hospital diagnosed at: _____

Diagnosis 3: _____

Date diagnosed: _____

Diagnosed by whom (name/credentials): _____

Agency or hospital diagnosed at: _____

Any past or inactive diagnoses:

_____

Current medications:

Name of Medication	Dose/Frequency	Prescribed by:

Please attach medication list if more space is needed

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Medication compliance:

_____

Medication allergies: ☐Y ☐N

If yes, list:

_____

Substance Use History: ☐Y ☐N

If yes, describe:

_____

Developmental Disorder (DD) Services: ☐Y ☐N

Describe any services the client received or currently receives:

_____

Support Administrator: _____ Phone Number: _____

Physical Conditions:

Date of last negative TB test (within 1 week of admission):

_____

Date of last physical exam: _____

Please check all that apply:

Ambulatory problems	☐	Asthma/COPD/ Respiratory	☐	Eating Disorder	☐	Gastrointestinal problems	☐
Diabetes	☐	Hypertension	☐	Dental problems	☐	Other	☐
Visual Impairment	☐	Epilepsy	☐	Incontinence	☐		☐
Hearing Impairment	☐	Allergies	☐	Sleep disorder	☐		☐
High Cholesterol	☐	Cardio Vascular	☐	Tobacco user	☐		☐

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Please explain any identified physical conditions, current treatment, and need for ongoing treatment:

_____

Previous/Current Criminal Justice System Involvement: ☐ **Y** ☐ **N**

Describe:

_____

Current probation/parole: ☐ **Y** ☐ **N**

Name of probation/parole officer: _____

Phone #: _____

Registered sex offender: ☐ **Y** ☐ **N**

History of Violence: ☐ **Y** ☐ **N**

If yes, please describe history and past intervention or treatment received:

_____

Risk of Violence: ☐ **Y** ☐ **N**

If yes, explain:

_____

Independent Living Skills: Please rate skills using scale below:

UKN	Insufficient Information to Assess
N/A	Do Not Apply
1	Can Manage Independently
2	Needs occasional/instruction/supervision/direction
3	Needs regular-not constant instruction/supervision/direction
4	Needs continual-consistent instruction/supervision/direction

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Skill Rating	N/A	UNK	1	2	3	4
Transportation	◯	◯	◯	◯	◯	◯
Keeping/Scheduling/ Appointments	◯	◯	◯	◯	◯	◯
Shopping	◯	◯	◯	◯	◯	◯
Cooking	◯	◯	◯	◯	◯	◯
Money Management	◯	◯	◯	◯	◯	◯
Laundry	◯	◯	◯	◯	◯	◯
Caring for physical conditions	◯	◯	◯	◯	◯	◯
Cleaning	◯	◯	◯	◯	◯	◯
Following Daily Routine	◯	◯	◯	◯	◯	◯
Medication Compliance	◯	◯	◯	◯	◯	◯
Grooming/hygiene	◯	◯	◯	◯	◯	◯
Setting limits on behaviors	◯	◯	◯	◯	◯	◯
Ability to assess and verbalize needs	◯	◯	◯	◯	◯	◯

Narrative Summary – Please describe in detail the necessity for admission to a Class One Residential Facility, particularly related to the need for MH Class 1 Rehabilitation Center (most restrictive setting/highest level of care):

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Service provider agency information:

Agency Name: _____ Office: _____

Phone #: _____

CPST Worker: _____ Phone # (cell if possible): _____

Case Worker Email: _____

Case Worker Supervisor: _____ Phone # (cell if possible): _____

Case Worker Supervisor Email: _____

Guardian: ☐ Y ☐ N

Name: _____ Phone # (cell if possible): _____

Signatures:

Client Signature: _____

Date: _____

Client Name (please print): _____

Date: _____

Guardian Signature (if applicable): _____

Date: _____

Guardian Name (please print): _____

Date: _____

Social Worker Signature: _____

Date: _____

Social Worker Name (please print): _____

Social Worker Phone Number: _____ Extension: _____

Social Worker Email: _____

Please email applications to:

ORCA/Cuyahoga County: ORCAReferrals@shinc.org

CH Everett/Lake County: EverettReferrals@shinc.org

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Personnel Responsible: Hospital / Crisis
Unit Staff
Audience: Community, ADAMHS boards
Communication: Email and our website, and ADAMHS boards from referring counties

The form is the application for admission to the Adam and Amanda Programs at ORCA House and C.H. Everett Clinic. The form will be used by hospital and/or crisis unit staff to refer patients to the program for mental health rehabilitation after being released from a hospital or crisis unit to continue mental health treatment and transition back into the community.

Guidelines

1. Who Should Complete the Form
    a. Form should be completed by outside community members
2. Where the form should be saved
    a. Once this form is received, SH staff members should make sure a copy of the completed form is placed in the patient's residential file and scanned into their epic chart.
3. Additional Information for SH Providers
    a. SH staff should get signed releases for any support people listed on the referral form for the patient to have saved in their file and scanned into their epic chart.

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