Residential Admission Form – ORCA and Everett

Welcome to Signature Health!

Thank you for considering Signature Health as your partner in caring for our community. At our Residential Treatment Centers, we prioritize both mind and body to support individuals on their healing journey and help them reach their full potential.

Signature Health offers three therapeutic residential programs for individuals needing intensive behavioral health support.

- C.H. Everett Clinic (Mentor): Adam & Amanda Residential Treatment for Mental Health
- ORCA House (Cleveland)
    - Adam & Amanda Residential Treatment for Mental Health
    - Medically Monitored Residential Treatment (ASAM 3.7) for Substance Use Disorders

Admissions Process

Prospective residents or their representative should complete this admission application and email it to:

- **ORCA House**: ORCAreferrals@shinc.org
- **C.H. Everett Clinic**: Everettreferrals@shinc.org

Our admissions team monitors this email Monday–Friday, 8:00 a.m.–5:00 p.m., and can respond to questions about our services, criteria, and costs – typically within 2 hours. During the weekends, please contact us at 216-231-3772 (ORCA) or 440-571-5520 (Everett). If your application responses reflect that our program will meet your needs, we will schedule a brief intake interview to confirm admission.

Eligibility Requirements

Residents should be capable of participation in daily activities, including:

- Participation in group and individual counseling
- Household responsibilities
- Structured non-clinical activities

Residents must:

- Be capable of completing daily activities (e.g., bathing, walking)
- Self-manage medications with minimal assistance
- Not pose a danger to themselves or others
- Not require skilled nursing or close monitoring.

Please note: Submission of this application confirms your review of these criteria and verifies that the prospective resident meets our eligibility requirements.

Learn more about our integrated healthcare services, specializing in mental health and addiction, at www.signaturehealth.org.

Effective: December 2024
Owner: Residential Services
Contact: Shayna Jackson, MSSA, LISW-S
Last Revised: 11/27/24
Last Reviewed by DSC: 12/03/24

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Demographics:

Patient Name: _____

Current Address:

_____

Previous Address:

_____

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

County of Residence: _____

Gender Identity: _____Pronouns: _____

Previous Living Arrangement:

Behavioral Health History:

Psychiatric Hospitalization Data:
Recent Hospitalization Date: ____/____/____ Name of Hospital: _____
Anticipated Discharge Date: ____/____/____ # days hospitalized in the past month: ___

Current Behavioral Health Diagnoses:
Diagnosis 1: _____ Date Diagnosed: _____ By Whom: _____
Diagnosis 2: _____ Date Diagnosed: _____ By Whom: _____
Diagnosis 3: _____ Date Diagnosed: _____ By Whom: _____

YES	NO	Question	If Yes, please explain
☐	☐	Are there any suicidal ideations?	
☐	☐	Are there any previous suicide attempts?	
☐	☐	Are there non-suicidal self-harming behaviors?	
☐	☐	Is there a history of violence?	
☐	☐	Is there history of problematic substance use?	

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Criminal Justice History:

YES	NO	Question	If Yes, please explain
☐	☐	Is there previous/current criminal justice involvement?	
☐	☐	Is there a current probation officer?	If Yes: Name_____ Phone#:_____
☐	☐	Is the patient a registered sex offender?	

Medical History:

PLEASE ATTACH A CURRENT LIST OF ALL MEDICATIONS INCLUDING MEDICATION NAME, STRENGTH, DOSE, AND FREQUENCY.

Date of last negative TB test (must be within 1 week of admission): ____/____/____

☐ Yes ☐ No – Are there any known drug allergies?
If yes, please describe:

_____

Please list any medical conditions, including current and chronic:

_____

Please check if any of the following conditions are present:

YES	NO	Condition	If Yes, please explain
☐	☐	Urinary incontinence	
☐	☐	Difficulty walking/ambulating	
☐	☐	Visual or hearing impairment (circle)	
☐	☐	Epilepsy	
☐	☐	Respiratory difficulty	
☐	☐	Poorly controlled chronic condition (diabetes, hypertension, COPD, etc.)	
☐	☐	Environmental or food allergies (circle)	
☐	☐	Difficulty eating or eating disorder	

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Service Provider Agency Information:

Agency Name:	Office:	Phone:
Case Manager Name:		
Phone (mobile if possible):		
Email:		
Case Manager Supervisor Name:		
Email:		
Guardian (if applicable):		
Phone (mobile if possible):		

ORCA SUD Residential Applicants Only (all others skip to Required Signatures)

Describe current substance use disorders and associated negative consequences:

_____

Recommended ASAM Level of Care (if known): _____

Required Signatures:

Client Name: _____

Client Signature: _____ Date:_____

Guardian Name (if applicable):_____

Guardian Signature: _____ Date:_____

Agency Service Provider Name: _____

Service Provider Phone Number: _____-_____-_____ Email:_____

Service Provider Signature: _____ Date:_____

EMAIL COMPLETED APPLICATIONS TO:

ORCA/Cuyahoga County: ORCAReferrals@shinc.org
CH Everett/Lake County: EverettReferrals@shinc.org

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