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:

____

____

____

Effective: 12/08/23
Owner: Holly Kirk/Behavioral Health
Contact: Jessica Reilly
Last Revised: 12/08/23
Last Reviewed by DSC: 12/08/23

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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:

____

____

Psychiatric Hospitalization Data

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

Form: Adam and Amanda Program Application

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.

<u>Guidelines</u>

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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