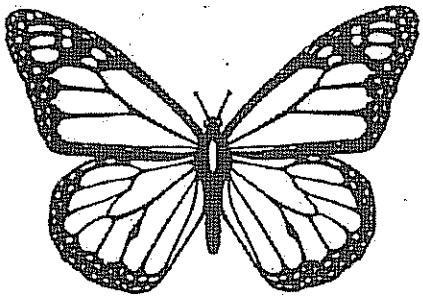
O'Brien House Referral/ Screening Packet



1. ASI Assessment
2. Required Documents
3. OBH Pre-Screening Form
4. TB Documentation

O'Brien House

Saving lives and families from addiction since 1971

446 N. 12th Street | Baton Rouge, LA 70802 | Phone: 225.344.6345 | Fax: 225.615-8875
www.obrienhouse.org | info@obrienhouse.org

REQUIRED DOCUMENTS CHECK LIST

Dear_____:

In order to make our intake process run more smoothly we are asking that you send us the following documentation via fax/email. Your assistance in this matter would be greatly appreciated. Please see below the information in which we are requesting.

____State Identification

____Social Security Card if Available

____Approximate Income for the last 12 months

____ASI or Psychosocial

____TB Skin Test Results (Required)

____OBH Pre-Screening Forms

____Letter of Referral (Printed on Facility Letterhead Stating Client Is Homeless or Is at Risk of Becoming Homeless)

____Medicaid Number (Include Bayou Health Carrier)

____Medicare Number

____Copy of Medicaid Application

Thanking you in advance for your cooperation in the matter.

Sincerely,

Ilisha Lucas
Intake Coordinator

Revised 11/04/15

Louisiana Department of Health and Hospitals

Authorization to Release or Obtain Health Information
(including paper, oral and electronic information)

Name:	Request Date:
Mailing Address:	Date of Birth:
City/State/Zip:	Medicaid # or Social Security #:

I authorize:

Name: O'Brien House

Mailing Address: 1231 Laurel Street

City, State, Zip Code: Baton Rouge, LA 70802

Relationship: Treatment Telephone Number: (225) 344-6345

☒ **TO RELEASE Information TO** OR ☒ **TO OBTAIN Information FROM**

(Place an "X" in the box that indicates if the information is being released OR requested.)

Name: _____

Mailing Address: _____

City, State, Zip Code: _____

Relationship: _____ Telephone Number: _____

The **Purpose of this Authorization** is indicated in the box(es) below. *(Place an "X" in the box(es) that apply.)*

☐ Further Medical Care ☐ Personal ☐ Legal Investigation or Action ☐ Changing Physicians

☐ Research related treatment ☐ Creating health information for disclosure to a third party.

☒ Other: (Specify) Substance Abuse Treatment Referral Information

I authorize the release of the following protected health information.
(Place an "X" in the box(es) that apply to the information you want released or you want to obtain.)

☒ Entire Record ☐ Medical History, Examination, Reports ☐ Surgical Reports ☐ Treatment or Tests
☐ Prescriptions ☐ Immunizations ☐ Hospital Records including Reports ☐ Laboratory Reports
☐ X-ray Reports ☐ MR/DD Records ☒ Other: TB Test Results

In compliance with state and/or federal laws which require special permission to release otherwise privileged information, please release the following records.

☒ Alcoholism ☒ Drug Abuse ☒ Mental Health ☒ Vocational Rehabilitation ☒ HIV (AIDS)
☒ Sexually Transmitted Diseases ☐ Genetics ☒ Psychotherapy Notes
☐ Other _____

This authorization shall expire on _____ **(date or event) and is needed for the period beginning** _____ **and ending** _____.

I understand that if I do not specify an expiration date, this authorization will expire six (6) months from the date on which it was signed. I acknowledge that I have read both pages 1 and 2 of this form.

_____ _____
Signature of Individual or Personal Representative Authorized by Law Date

_____ _____
Signature of Witness *(If signed with an "X" or mark)* Date

For DHH Use When Requesting Records

I am authorized to receive this disclosure. Documentation on the above Personal Representative has been obtained.

_____ _____
Signature and Title of Agency Representative Date

FEE DETERMINATION FORM

CLIENT NAME: _____ SSN: _____
MAILING ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
NO IN FAMILY UNIT: _____

ANNUAL AMOUNT BY FAMILY MEMBER BY SOURCE

INCOME SOURCE	CLIENT	RESPONSIBLE PARTY	SPOUSE	OTHER FAMILY MEMBER	TOTAL INCOME FOR SOURCE
Wage or Salary	$	$	$	$	$
Self-Employ (Net)	$	$	$	$	$
Social Security	$	$	$	$	$
SSI	$	$	$	$	$
Dividends, Interest	$	$	$	$	$
Retirement	$	$	$	$	$
Pensions, Annuities	$	$	$	$	$
Veteran's Pension	$	$	$	$	$
Unemploy Comp	$	$	$	$	$
Alimony	$	$	$	$	$
Child Support	$	$	$	$	$
Public Assistant	$	$	$	$	$
Other:	$	$	$	$	$
TOTAL ANNUAL FAMILY INCOME					$
Number of Dependents					

MEDICAID NUMBER: _____ MEDICARE NUMBER: _____
INSURANCE CO: _____ POLICY #: _____ INSURED: _____
INSURANCE CO: _____ POLICY #: _____ INSURED: _____
Facility Representative: _____ Date: _____

I CERTIFY that the information given above is correct to the best of my knowledge. Further, I give my consent for the agency to verify any of the income listed above through the Department of Labor.

_____ _____
Signature of Client or Responsible Party Date

_____
NOTARY PUBLIC

This document must be notarized to be considered as a valid proof of income.

OBH PRE-SCREENING FORM

Date: _____ Client Availability date: _____

Name: _____ Address: _____

Age: ____ Sex: _____ Race: _____ Birthdate: _____ SS#: _____

Referral Source: _____ Contact Name: _____ Contact #: _____

Substance Abuse History

Name, date, and # of times in: **Outpatient:** _____

Inpatient: _____ **Detox:** _____

Ever been a client at O'Brien House? YES or NO If so, when? _____

Is client currently clean? YES or NO *Must provide a clean urine screen*

1st DOC: _____ Amt/Frequency: _____ Last use: _____ Age at 1st use: ____

2nd DOC: _____ Amt/Frequency: _____ Last use: _____ Age at 1st use: ____

3rd DOC: _____ Amt/Frequency: _____ Last use: _____ Age at 1st use: ____

Mental Health History: Circle all that apply-current and/or in lifetime

ADD/ADHD Schizophrenia Bipolar PTSD Depression Anxiety
Hallucinations Auditory (hearing voices) Personality Disorders Violent behavior Homicidal
Suicidal ____ideation ____attempts

Any mental health problems not listed above:

_____

Current psych meds: _____

History of psych meds: _____

Explanation of ALL above: _____

Every attended outpatient or inpatient for psych issues? YES or NO

Medical History: Circle all that apply-current and/or in lifetime

Respiratory Stomach condition Skin condition Kidney condition Stroke Hypertension
Vision condition Heart/Circulation Seizure disorder Diabetes Back problems
Liver condition Pancreas condition Infectious condition (HIV, TB, Hep C) Other (that is not listed)

List current medications: _____

List current medical problems: _____

Any physical disabilities? YES or NO If yes, please list: _____

Is client ambulatory? YES or NO Is client able to work or do service work? YES or NO

OBH PRE-SCREENING FORM

Legal

Court ordered? YES or NO If yes, which court system? _____
If yes was client given the freedom of choice for which facility to attend? YES or NO
Is client on probation or parole? YES or NO

If yes, name and # of officer: _____

List all legal charges:

_____
_____

List all convictions:

_____
_____

Explain charges and convictions:

_____
_____

If any above are Assault/Battery charges or any violent crimes, please explain in detail below:

_____
_____

Next court date?_____
Is client in drug court? YES or NO If yes, which court?_____

Military Information

Military? YES or NO What Branch? _____ Were you in deployed: YES or NO

If deployed, where? _____ Active Duty? _____ D/C Date? _____

Receiving veteran services? YES or NO

Special Population

If female are you pregnant? YES or NO Are you an IV Drug User? YES or NO
Are you a woman with dependent children? YES or NO

OBH Eligibility Requirements Checklist

A. Homeless (or at risk of becoming homeless due to addiction) _____
B. Voluntary _____
C. 18 years of age or older _____
D. Ambulatory _____
E. Physically and emotionally ready and willing to accept full time employment or if receiving disability able to complete service work _____
F. Willing to submit to random alcohol/drug screens _____
G. Must qualify based on ASAM level of care _____
H. Completed 28 day treatment within the last 6 months _____
I. Has provided completed TB test results from within the last year _____
J. 30 day supply of medication (psych or medical) _____

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Date: 12/19/2015

RE: TB MEMO

To Whom It May Concern:

Due to CARF requirements O'Brien House is mandating that prior to admissions to OBH a **negative TB** screening is required to be accepted. The TB screening should be no more than 12 months old. It should be attached to the application for admission that is sent to OBH.

A client with a positive TB test can be admitted to OBH **only** if the client is in the **latent phase** of the disease and is currently receiving treatment. If the client is in the active phase of the disease they will not be admitted until course of treatment is completed and they have received clearance from a medical professional stating that they can be removed from isolation and return to general population.

If a client has had a previous diagnosis of TB or TB exposure a chest x-ray completed with-in the last 5 years must be presented in place of the TB test stating that the client is negative for TB.

Thank you for your cooperation in the matter and O'Brien house looks forward to working with your organization in the future.

Sincerely,

EGeorge, LCSW, MPA

Emily C Georgg, LCSW, MPA
O'Brien House Clinical Director

O'Brien House is a 501 (c)(3) non-profit organization. Your contribution is tax-deductible to the extent allowed by law. No goods or services were provided in exchange for your generous financial donation.
For additional information about O'Brien House, please visit our website: www.obrienhouse.org.

If you wish to be removed from our mailing list or if you wish to remain an anonymous donor, please call (225) 344-6345 or send an e-mail to info@obrienhouse.org.