Admission Packet

Overview

Intensive Residential Treatment Services (IRTS) are time-limited (i.e., up-to 90 days) mental health (MH) services provided in a residential setting to adults in need of a more restrictive milieu and at risk of significant functional deterioration if they do not receive these services. The Landing is designed to develop and enhance psychiatric stability, personal and emotional adjustment, self-sufficiency, and skills to live independently. Treatment is directed to a targeted discharge date with specified goals and outcomes consistent with evidence-based practices (EBPs). The services are designed to promote individual choice and active involvement of the patient in the treatment process. Admission is based on specific criteria outlined in Minn. Stat. § 245I.23, Subd. 15 for IRTS and Minn. Stat. § 245I.23, Subd. 16 for Residential Crisis Stabilization (RCS) services.

IRTS Admission Criteria

1. Age 18 years of age or older.
2. Diagnosed with a mental illness (MI) according to dimensions outlined in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision* (DSM-5-TR).
3. Has the need for MH services that cannot be met with other available community-based services, or is likely to experience a MH crisis or require a more restrictive setting if intensive rehabilitative mental health services are not provided as determined by the written opinion of a mental health professional (MHP).
4. Functionally impaired because of MI, in **three or more areas** of a functional assessment (FA) pursuant to Minn. Stat. § 245.462, Subd. 11a.
   - ☐ Use of drugs and alcohol.
   - ☐ Vocational and educational functioning.
   - ☐ Social functioning, including the use of leisure time.
   - ☐ Interpersonal functioning, including relationships with the adult's family.
   - ☐ Self-care and independent living capacity.
   - ☐ Medical and dental health.
   - ☐ Financial assistance needs.
   - ☐ Housing and transportation needs.
   - ☐ Other needs and problems.
5. Additionally, **one or more** of the following:
   - ☐ History of recurring or prolonged inpatient hospitalization in the past year.
   - ☐ Significant independent living instability.
   - ☐ Homelessness.
   - ☐ Frequent use of MH and related services yielding poor outcomes

RCS Admission Criteria

1. Age 18 years of age or older.
2. Positive screen for potential MH crisis.
3. Assessed during a crisis to be experiencing a MH crisis.

Application

Individuals who are likely not appropriate for IRTS admission include: (1) substantial risk of harm to self, others, and/or property or are unable to care for their own physical health and safety in a life-endangering situation (e.g., fire), (2) believed to have used alcohol of sufficient amount and duration to create a reasonable expectation of withdrawal upon cessation of use, and (3) those who have complex medical or other serious health care conditions. Please contact admissions at admissions@landingmn.com or (844) LANDING. Complete and submit the following for admission consideration. This may be done electronically online or via facsimile at (651) 448-2147.

1. Case manager referral form.
2. Pre-admission medical and physical requirements form by licensed provider or qualified nurse practitioner (PNP).
3. Confirmation and list of current medications prescribed.
4. Verification of funding source.
5. Program director recommendation.

Case Manager Referral Form

Please attach the most recent: (1) diagnostic assessment (DA), (2) level of care utilization system (LOCUS) assessment, and (3) functional assessment (FA).

Patient Information

Patient Name:		Date of Birth (DOB):	
Patient Age:		Ethnicity:	
Sexual Orientation:		Gender Identity	
Religion:		Spirituality:	
Language Preference:		Employed:	Yes ☐ No ☐
Highest Education:		Employment Type:	
Financial Concerns:	Yes ☐ No ☐	Veteran:	Yes ☐ No ☐

Legal Status: Voluntary ☐ Commitment ☐ Stay of Commitment ☐ Guardianship ☐

Referent Information

Referent Name:		County of Responsibility:	
Referent Title:		Phone Number:	
Referent Agency:		Fax Number:	
Agency Location:		E-Mail Address:	

Clinical Impression and Diagnoses

Reasons for Placement

Goals for Placement

Patient Financial Information

Monthly Gross: | Reductions:
Employer: | Employer Phone Number:

Patient Income Source

- ☐ Employment
- ☐ Veterans Affairs Disability
- ☐ General Assistance
- ☐ Retirement Survivors Disability Insurance
- ☐ Social Security Income Pending
- ☐ Other:
- ☐ Unemployment Insurance
- ☐ Workermen's Compensation
- ☐ General Assistance and Medical Care
- ☐ Social Security Income
- ☐ Retirement

Patient Housing Source

- ☐ Section 8
- ☐ Crisis Housing Fund
- ☐ Bridges
- ☐ Other:

Patient Funding Source

- ☐ Medical Assistance
- ☐ Minnesota Care
- ☐ Medical Assistance Pending
- ☐ Private or Commercial

Patient Funding Source

Medical Assistance, Person Master Index:
Effective Date:
Insurance Name:
Insurance Number:
Insurance Group Number:
Pre-Authorization Required: Yes ☐ No ☐

Additional Consideration

The following information is required before intake:

- ☐ Copy of the court findings, if a patient is on a full commitment or stay of commitment, which indicates the type of commitment as well as a copy of the provisional discharge (PD).
- ☐ Copy of completed health and physical (H&P) within 30 days that includes: (1) medical history, (2) immunization record, and (3) statement that patient is free of communicable diseases signed by a physician or qualified NP.
- ☐ Three-day supply of current medications.

Health History

Patient Information

Patient Name:		**Date of Birth (DOB):**	
Patient Age:		**Ethnicity:**	
Sexual Orientation:		**Gender Identity**	
Religion:		**Spirituality:**	
Language Preference:		**Employed:**	Yes ☐ No ☐
Highest Education:		**Employment Type:**	
Financial Concerns:	Yes ☐ No ☐	**Veteran:**	Yes ☐ No ☐

Provider and Assessment Information

Provider Name:		**Appointment Date:**	
Provider Credentials:		**Appointment Day:**	
Admission Date:		**Appointment Time:**	
Evaluation Type:	Initial ☐		Update ☐

Primary Health Complaint

Current Medications

Medication	Diagnosis	Dose	Frequency	Last Taken

Symptom Review

☐ Constitutional	☐ Gastrointestinal	☐ Psychiatric
☐ Eyes	☐ Genitourinary	☐ Endocrine
☐ Ears, Nose, Throat (ENT)	☐ Musculoskeletal	☐ Hematological
☐ Cardiovascular	☐ Integumentary	☐ Allergies
☐ Respiratory	☐ Neurologic	☐ Other: _____

Comments

Mental Status Examination (MSE)

Observations

Appearance	☐ Neat	☐ Disheveled	☐ Inappropriate	☐ Bizarre
Speech	☐ Normal	☐ Tangential	☐ Pressured	☐ Impoverished
Eye Contact	☐ Normal	☐ Intense	☐ Avoidant	☐ Erratic
Motor Activity	☐ Normal	☐ Restless	☐ Tics	☐ Delayed
Affect	☐ Full	☐ Constricted	☐ Flat	☐ Labile

Comments

Mood

☐ Euthymic ☐ Anxious ☐ Angry ☐ Depressed ☐ Euphoric

Comments

Cognitive Impairment

Orientation	☐ None	☐ Person, Place, and Situation	
Memory	☐ None	☐ Short-Term	☐ Long-Term
Attention	☐ None	☐ Distracted	☐ Erratic

Comments

Thoughts

Suicidality	☐ None	☐ Ideation	☐ Plan	☐ Intent	☐ Act
Homicidality	☐ None	☐ Aggression	☐ Intent	☐ Plan	
Delusions	☐ None	☐ Grandiose	☐ Paranoid	☐ Religious	

Comments

Behaviors

☐ Cooperative	☐ Withdrawn	☐ Paranoid
☐ Bizzare	☐ Hyperactive	☐ Aggressive
☐ Guarded	☐ Agitated	☐ Religious

Comments

Past Medical History

☐ Asthma	☐ GERD or Ulcers	☐ Neurological Disorders
☐ Bleeding Disorder	☐ Kidney Failure	☐ Seizures
☐ Cancer	☐ High Blood Pressure	☐ Sleep Disorder
☐ Cardiovascular	☐ High Cholesterol	☐ Eye Disorder
☐ Diabetes	☐ Migraines	☐ Other: _____

Comments

Family Medical History

☐ Asthma	☐ GERD or Ulcers	☐ Neurological Disorders
☐ Bleeding Disorder	☐ Kidney Failure	☐ Seizures
☐ Cancer	☐ High Blood Pressure	☐ Sleep Disorder
☐ Cardiovascular	☐ High Cholesterol	☐ Eye Disorder
☐ Diabetes	☐ Migraines	☐ Other: _____

Comments

Substance Use History

Substance	Age of First Use	Frequency	Last Use Date	Treatment	
				☐ Yes	☐ No
				☐ Yes	☐ No
				☐ Yes	☐ No
				☐ Yes	☐ No
				☐ Yes	☐ No

Summary and Recommendations

Attestation

Provider Signature

Date

Release of Information

Patient Information

Patient Name | Date of Birth (DOB)

Street Address | E-Mail Address

City | State | Zip Code | Phone Number

Releasing Party

Party Name

Street Address | E-Mail Address | Fax Number

City | State | Zip Code | Phone Number

Receiving Party

Party Name

Street Address | E-Mail Address | Fax Number

City | State | Zip Code | Phone Number

Release Purpose

- ☐ Continuing Care
- ☐ Insurance
- ☐ Other:
- ☐ Personal Use
- ☐ Social Security
- ☐ Legal
- ☐ Disability

Pursuant to Minn. Stat. § 144.294 and 45 CFR § 164.524, fees may be charged for release of documentation.

Information to be Released

I want my records related to:

I want my records for the following dates:

Individual Options

- ☐ Diagnostic Assessment
- ☐ Health History
- ☐ Functional Assessment
- ☐ Everything
- ☐ Individual Encounters
- ☐ Group Encounters
- ☐ Intake Forms
- ☐ Individual Abuse Prevention Plan
- ☐ Treatment Plan
- ☐ Locus of Care Assessment
- ☐ Immediate Needs Assessment

Method of Release

Date records are needed:

Individual Options

- ☐ Secure E-Mail
- ☐ U.S. Mail
- ☐ Non-Secure E-mail (i.e., Patient Only)
- ☐ Pick-Up
- ☐ Fax

Note: I acknowledge that by electing to receive my health information via e-mail in a non-secure manner that the information is not encrypted and that it could be intercepted and viewed by a third party. The Landing and Horowitz Health are not responsible for unauthorized access to your health information while in transmission to the e-mail address you designated above.

Note

By signing this authorization, you grant permission for the release of your information, which will remain valid for one year from the date of your signature, unless a different date or expiration is specified. This authorization can be revoked in writing at any time; however, any releases that occur prior to the revocation will still apply. It is important to note that declining to sign this authorization will not impede your access to treatment. Copies or faxes of this authorization hold the same weight as the original. Your records may encompass information received from other organizations, and if such records have been incorporated into your file at The Landing, they may also be disclosed. Keep in mind that The Landing cannot control the subsequent sharing of your information by the recipient, and this data may not retain the same state and federal privacy protections once it is released. By signing, you release The Landing from any liability stemming from the recipient's redisclosure of the information. Notably, under 42 CFR Part 2, unauthorized disclosure of substance use records is prohibited.

Patient or Authorized Representative Signature | Date