



Department of Behavioral Health, Developmental Disabilities and Hospitals

**ELEANOR SLATER HOSPITAL**  
**Admissions Department**  
**111 Howard Avenue**  
**Cranston, RI 02920**

**Office – 401-462-3433**  
**Fax – 401-462-6958**

**APPLICATION FOR ADMISSION – ADULT PSYCHIATRIC SERVICES**

*This application is to be completed by the Community Mental Health Center/other community agency*

Name of Applicant: \_\_\_\_\_

Residence: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender:  Male  Female U.S. Citizen:  Yes  No

Language Preference: \_\_\_\_\_

**INCLUDE PHOTOCOPIES OF ALL MEDICAL COVERAGE CARDS**

Social Security #: \_\_\_\_\_ Name of insured, if other than applicant: \_\_\_\_\_

Medicare #: \_\_\_\_\_ Federal  Medicare Replacement Plan (HMO)  Agency: \_\_\_\_\_

If supplemental plan to Medicare please specify: \_\_\_\_\_ ID #: \_\_\_\_\_

Blue Cross #: \_\_\_\_\_ Veteran's #: \_\_\_\_\_ Other: \_\_\_\_\_

Medical Assistance #: \_\_\_\_\_ ID #: \_\_\_\_\_

If pending, list name and contact number of office/worker to contact (R.I. only) \_\_\_\_\_

**ELEANOR SLATER HOSPITAL INFORMATION:**

Eleanor Slater Hospital (ESH) is a facility that provides Long-Term Care; patients accepted for admission **must qualify for hospital level of care**. In addition, attempts are made to accommodate patients' wishes, however the appropriate campus and unit for admission will be determined by the ESH Admission Team. Internal unit transfers between Cranston and Burrillville (Zambarano Campus) are at the discretion of the ESH clinical treatment team at any time following admission. For health and safety reasons, the patient and/or guardian must agree to basic care and personal hygiene throughout the duration of the hospital course. All least restrictive options must be exhausted prior to ESH referral and documented below. Documentation of all alternative referrals may be requested when applicable. Please note, for those patients receiving treatment from a community provider, i.e. community mental health center, an application from the acute care hospital and the community agency must be received in order for the ESH referral to be complete. The application will be considered a partial application and the applicant will not be considered for admission until both parties have submitted their portion of the application. It is the responsibility of the community providers to consult and agree upon ESH referral; ESH staff **will not** notify community providers when an application is incomplete. Once completed an ESH representative will notify the acute care hospital of the plan to proceed. If / when patients no longer qualify for hospital level services as determined by the current acute care treatment team, discharge to a less restrictive environment becomes mandatory under federal guidelines. Both the patient and family/guardian are to participate and support discharge planning efforts as deemed appropriate by the clinical treatment team. The patient and family/guardian will be notified prior to any such discharge referral.

The acute care hospital is in agreement with the ESH referral:  YES  NO

The acute care hospital has submitted their portion of the application:  YES  NO

DIAGNOSES/PROBLEMS:

1. (Primary Diagnosis)	4.
2.	5.
3.	6.

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RATIONALE FOR ESH REFERRAL:

1. Reason for current acute care hospitalization:

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2. Provide a description of the alternatives considered prior to this ESH referral and why they were considered unsuitable.

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3. Provide a description of any behavioral management issues of which the ESH admission team should be aware.

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4. Describe the behavioral/clinical goals your agency has for the patient's stay at the ESH and the criteria your agency is using to establish readiness for discharge. Please address all anticipated placement options.

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