



**Department of Behavioral Healthcare, Developmental Disabilities and Hospitals  
Mental Health Psychiatric Rehabilitative Residences  
Admissions Department  
14 Harrington Rd.  
Cranston, RI 02920**

**Office: 401-462-1323  
Fax: 401-462-1538**

**APPLICATION FOR ADMISSION**

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

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

**Date of Birth:** \_\_\_\_\_ **Sex:**  Male  Female **U.S. Citizen:**  Yes  No **Religion:** \_\_\_\_\_ **Marital Status:**  Single

Married  Civil Union  Widowed  Divorced **Current Legal Status:** \_\_\_\_\_ **Race:**  White  Black or African

American  American Indian  Asian  Native Hawaiian or other Pacific Islander  Mixed

**Ethnicity:**  Hispanic or Latino  Non-Hispanic or Latino **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 #:** \_\_\_\_\_

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

*Referral from (hospital, nursing home, community agency, etc.):*

**Name:** \_\_\_\_\_ **Address:** \_\_\_\_\_

**Contact Name:** \_\_\_\_\_ **Telephone:** \_\_\_\_\_

*Family, significant other supports*

<u>Name</u>	<u>Address</u>	<u>Telephone (home/work/cell)</u>	<u>Relationship</u>
_____	_____	_____	_____
_____	_____	_____	_____

*How often have family, significant other supports visited the applicant in the last two months?*

- Daily  2-3 times per month  
 More than a week  Once a month  
 Once a week  Less than once a month  N/A

*How often have they provided care/assistance to the applicant in the last two months?*

- Daily  2-3 times per month  
 More than a week  Once a month  
 Once a week  Less than once a month  N/A

**Advanced Directive: Please provide copies of any known "Advanced Directive".**

- Living Will:  Yes  No  
Durable Power of Attorney for Healthcare:  Yes  No  
Is Guardianship pending?  Yes  No

**Communication Preferences**

- Mail  
 Phone \_\_\_\_\_  
 \*Email \_\_\_\_\_

Applicant's Signature (If unable to sign, guardian or relative) \_\_\_\_\_

Date

\*No personal health information can be sent via email

MHPRRs are facilities that provide Long-Term Care; patients accepted for admission **must qualify for a group home level of care**. If / when clients no longer qualify for group home level services as determined by the treatment team, discharge to a less restrictive environment becomes mandatory under federal guidelines.

To be considered for placement in a MHPRR, an individual shall be eighteen (18) years or older and not under the jurisdiction of the Department of Children, Youth and Families, be diagnosed with a serious and persistent mental illness (i.e. meet the eligibility criteria for treatment in a Community Support Program), and demonstrate an inability to receive care and treatment in a less restrictive community setting by reason of his/her serious and persistent mental illness. Supporting documentation (i.e. treatment records) is required.

Identify which of the following priority placement criteria met by this client:

- (a) A history of being incarcerated, or institutionalized, or in a controlled environment of any kind, including, but not limited to, admission to: the Eleanor Slater Hospital, the Forensic Service at the Eleanor Slater Hospital, or the ACI ;
- (b) Exhibits dangerous behavior and/or has a history of violence that requires close supervision and a highly structured setting to ensure the safety of the individual and/or the community;
- (c) Requires assistance to complete daily living and self-care tasks;
- (d) A co-occurring physical health problem, developmental disability, and/or substance use disorder that requires more intensive treatment, monitoring, and support than can be provided in a less restrictive community setting;
- (e) Has received care and treatment pursuant to a Court Order for Outpatient Treatment and the individual's compliance with said order; and
- (f) The number of psychiatric hospitalizations in the past year. Number \_\_\_\_\_

Does the patient have a discharge goal after MHPRR?  Yes  No

If yes what is the goal:     Home alone                       Assisted living  
    Home with family  
    Other (Please specify): \_\_\_\_\_

If no discharge goal exists, please explain long-term goals for this patient 1-5 years from now:

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Who is the primary mental health treatment provider currently? \_\_\_\_\_

**ALL INFORMATION MUST BE COMPLETE AND ACCURATE. PLEASE INCLUDE COPIES OF SUPPORTIVE DOCUMENTATION:** *Physician progress notes, physician orders, nurses notes, consultations, therapists notes, etc.*

To be completed by physician, nurse, or case manager – please check appropriate boxes.

MEMORY

- Normal
- Mildly impaired
- Moderately impaired
- Severely impaired

COMMUNICATION

- Normal
- Language barrier
- Comprehends
- Can relate needs
- Aphasic/non-communicative

BEHAVIOR

- No significant disorder
- Appears depressed
- Wanders
- Noisy
- Withdrawn
- Physically assaultive
- Verbally abusive
- Intrusive
- Combative during care
- Sexually inappropriate

SENSORY

- Hearing impairment
- Vision Impairment

DSM Diagnoses

I. \_\_\_\_\_  
 II. \_\_\_\_\_  
 III. \_\_\_\_\_

IV. \_\_\_\_\_  
 V. \_\_\_\_\_

MEDICATIONS (Dose & Routine)

_____	_____
_____	_____
_____	_____
_____	_____

PROGNOSIS    Good    Fair    Poor    Guarded

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

PHYSICIAN VERIFICATION

Name of Physician: \_\_\_\_\_ Telephone: \_\_\_\_\_ Date of last examination: \_\_\_\_\_  
 (Print)

Signature of Physician: \_\_\_\_\_ Date: \_\_\_\_\_

