BRYNN MARR HOSPITAL

PRTF APPLICATION CHECKLIST

Information Needed to Submit Application

- ❖ Complete Application
- ❖ Copy of Insurance Card
- ❖ Copy of Identification Card for Guardian(s)
- ❖ Necessary Clinical Documents:

Medicaid

- Comprehensive Clinical Assessment and Person-Centered Plan with Brynn Marr PRTF specific goals
- Certificate of Need

Tricare

- Tricare Applications from Legal Guardian ***and*** Physician
- Clinical assessments supporting PRTF level of care

Most Commercial Insurances

- Physician and Clinical Assessments with PRTF Recommendation and History of All Previous Placements

Documentation Required for Admission (After Acceptance)

- ❖ School Records: IEP, Final Grades, Suspensions, etc.
- ❖ Immunization Record
- ❖ Psychological Testing (If Applicable)
- ❖ History & Physical
- ❖ Current Treatment Plan
- ❖ Birth Certificate
- ❖ Recent PPD Results (If Applicable)
- ❖ All Hospital Consent Forms

PLEASE RETURN ALL INFORMATION TO:

Brynn Marr Hospital Admissions
Phone:
(910) 577-1900
Fax: (910)-577-2799

PRTF APPLICATION

1. PERSON/AGENCY COMPLETING APPLICATION

NAME: _____

ADDRESS: _____

TELEPHONE: _____

FAX: _____

2. APPLICANT

NAME: _____

ADDRESS: _____

CITY: _____

STATE: _____ ZIP: _____

TELEPHONE #: _____

DOB: _____ AGE: _____ SEX: _____

SSN #: _____ RACE: _____

MEDICAID #: _____MCO:_____

3. LEGAL CUSTODY

LEGAL GUARDIAN: _____

RELATIONSHIP TO APPLICANT: _____

ADDRESS: _____

CITY: _____ STATE: _____

ZIP: _____ TELEPHONE #: _____

HAVE PARENTAL RIGHTS BEEN TERMINATED? ☐ Yes ☐ No

DATE: _____

HAS PATIENT BEEN ADOPTED? ☐ Yes ☐ No

DATE OF FINAL ADOPTION ORDER: _____

PATIENT'S SIBLINGS

Name	Age	Relationship	Presently Lives With

4. MEDICAL

MEDICAL PROBLEMS/PAST SURGERIES (INCLUDE DATES):

_____

ALLERGIES, ADVERSE DRUG REACTIONS:

_____

PATIENT'S PRIMARY CARE PHYSICIAN:

NAME: _____ TELEPHONE: _____

ADDRESS: _____

PATIENT'S DENTIST:

NAME: _____ TELEPHONE: _____

ADDRESS: _____

CURRENT/PAST SYMPTOMS:

PAST/PRESENT SUICIDAL/HOMICIDAL IDEATION/GESTURE/ATEMPT:

_____

_____

_____

PAST/PRESENT HISTORY OF PSYCHOSIS:

_____

_____

_____

HISTORY OF PHYSICAL/SEXUAL ABUSE/NEGLECT:

_____

_____

_____

HISTORY OF ELOPEMENTS:

_____

_____

_____

HISTORY OF CHEMICAL DEPENDENCY

Type	Amount	Frequency	Last Use

CURRENT MEDICATIONS

Medication	Dosage	Frequency

5. LEGAL ISSUES

Charges	Outcome

PROBATION OFFICER/COURT COUNSELOR TELEPHONE #

_____ _____

INPATIENT HOSPITALIZATION(S) WITHIN THE LAST YEAR

Hospital	Dates

OUTPATIENT TREATMENT

Name	Agency	Telephone #

GROUP HOME PLACEMENT (IN LAST TWO YEARS)

Group Home	Address	Dates

RESIDENTIAL PLACEMENT (IN LAST TWO YEARS)

Center Name	Address	Dates

OTHER AGENCY INVOLVEMENT (GAL, DSS, ETC.)

Agency	Contact Person	Telephone #

6. ACADEMICS

ASSIGNED SCHOOL GRADE: _____ RETAINED? WHICH GRADE: _____

EDUCATIONAL SETTING:

REGULAR CLASS _____ SPECIAL ED _____ OTHER _____

HAS PATIENT BEEN CLASSIFIED AS SPECIAL NEEDS UNDER PL 105-17?

AU BED C/B HI EMD TMD SPD MU OI OHI SLD SLI VI

HAS PATIENT BEEN SUSPENDED/EXPELLED IN LAST SCHOOL YEAR?

PLEASE LIST AND EXPLAIN INCIDENTS:

_____

_____

7. PLEASE LIST OTHER RESDIENTIAL FACILITIES APPLIED FOR

_____

_____

_____

8. CURRENT SYMPTOMS AND FUNCTIONING REQUIRING TREATMENT IN PRTF:

_____

_____

9. CHRONIC BEHAVIORS:

_____

_____

Clinically approved by Brynn Marr Hospital on _____

_____

Signature with credentials