BRYNN MARR HOSPITAL

PRTF PASSAGES PROGRAM APPLICATION CHECKLIST

Information Needed to Submit Application

- ❖ Complete Application
- ❖ Other Necessary Clinical Documents:

Medicaid

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

Tricare

- Tricare Application
- Clinical assessments supporting PRTF level of care

Most Commercial Insurances

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

Other Documents That *May* Be Requested:

- ❖ Psychiatric Evaluation
- ❖ Psychological Testing (if applicable)
- ❖ History & Physical or other medical documents if applicable

Documentation Required for Admission (After Acceptance)

- ❖ Copy of Insurance Card
- ❖ Copy of Identification Card for Guardian
- ❖ School Records: IEP, Final Grades, Suspensions, etc.
- ❖ Immunization Record
- ❖ 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/AGENCY: _____

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:

_____

_____

_____

Signature with credentials