BEYOND FAMILY LIVING Inc.

Referral Intake PreScreen Package

Please ensure that all sections of these forms are completed. Submitting an incomplete form may delay the placement process.

The referral WILL NOT be accepted without a 30-days supply of medication or prescriptions for all current medications taken.

BEYOND FAMILY LIVING

www.beyondfamilyliving.org

Respite/Referral/Pre-Screening Form

Name:	Age:	Date:
SS#:	County Agency:	

These questions are to be used to guide discussion with the individual, family, and his/her caregivers about any possible indicators that a mental health evaluation may be necessary. A "yes" response to any of these questions may be an indicator that someone might be experiencing a mental health problem and a further assessment and/or referral to mental health services may be required.

Questions

Behavioral/Mental Health Changes	Yes	No
1. Has there been a change in the way that the person reacts/interacts with caregivers?	☐	☐
2. Does the person hurt him/herself or others?	☐	☐
2a. If yes, is this behavior new?	☐	☐
3. Has the person been sleeping more or less than usual?	☐	☐
4. Has there been a significant change in the person's level of activity?	☐	☐
5. Is the person overly fearful?	☐	☐
5a. If yes, is this behavior new?	☐	☐
6. Does the person seem sadder or appear to be more socially withdrawn than they have in the past?	☐	☐
7. Is the person extremely confused or disoriented?	☐	☐
7a. If yes, is this behavior new?	☐	☐
8. Does the person hear voices even when no one is there? (This is not the same thing as talking to oneself for company or to reduce anxiety.)	☐	☐
8a. If yes, is this behavior new?	☐	☐
9. Does the person have a current or past psychiatric or mental health diagnosis?	☐	☐
9a. Does the person currently take medication for mental health or behavioral issue(s)?	☐	☐
9b.Is the person currently under treatment with a psychiatrist, APN, primary care physician or another type of mental health therapist?	☐	☐

10. Is there a current behavior plan in place?	☐	☐
11. Has the person ever attempted to commit suicide? *If yes, a safety plan is required to be outlined in the ISP/IEP	☐	☐
12. Has the person verbalized a desire to commit suicide? **Please note, a "yes" will require a direct referral to Crisis Intervention Line	☐	☐

Behavioral/Mental Health Changes Follow up		
Are any of these changes/behaviors interfering with the person's day to day functioning?	☐	☐
Regarding the above questions, mark the box that indicates the type of follow up necessary:		
☐	Currently being managed with no additional follow-up needed	
☐	Referral to Robinson Counseling Center and/or Children's Service Center	
☐	Revise ISP/EIP to address newly identified supports and service needs	
Please describe the necessary follow up:		

Physical/Medical Changes	**Yes**	**No**
13. Has there been a change in the person's appetite?	☐	☐
14. Has the person gained or lost weight recently?	☐	☐
15. Was the last medical evaluation more than a year ago?	☐	☐
16. Have there been any recent medication changes?	☐	☐
17. Is the person addressing his/her own health and wellbeing needs?	☐	☐
18. Has the person recently been hospitalized for a severe medical condition?	☐	☐

Physical/Medical Changes Follow up		
Are any of these changes interfering with the person's day to day functioning?		
Regarding the above questions, mark the box that indicates the type of follow up necessary:		
☐	Currently being managed with no additional follow-up needed	
☐	Referral to Robinson Counseling Center, Medical Doctor, and/or reach out to HMO Care Manager to refer to appropriate mental health/ appropriate services needed	
☐	Revise ISP/EIP to address newly identified supports and service needs	
Please describe the necessary follow up:		

Life Circumstance Changes	**Yes**	**Mo**
19. Has there been any recent change to the person's environment or life circumstances that appear to be stressful or uncomfortable to them? (Examples: new roommate, death of someone close to them, new staff, etc…)	☐	☐

20. Has the person experienced any traumatic events recently (examples: a car accident, loss of a loved one or caregiver, victim of a crime)?	☐	☐

Life Circumstance Changes Follow up
Are any of these changes interfering with the person's day-to-day functioning?
Regarding the above questions, mark the box that indicates the type of follow up necessary:
☐ Currently being managed with no additional follow-up needed
☐ Referral to Robinson Counseling Center and/or Children's Service Center
☐ Revise ISP/EIP to address newly identified supports and service needs
Please describe the necessary follow up:

Additional Comments:

Case Worker/Case Manager (Print)	Signature	Date

Case Worker/Case Manager Supervisor (Print)	Signature	Date

*****Please provide copies of child's IEP/ISP, Behavioral Plan, Psychiatric Evaluation, Medical History with a list of all current medication. *****

BEYOND FAMILY LIVING, INC.

REFERRAL INFORMATION SHEET

(ALL SECTIONS MUST BE COMPLETED)

Individual's Name:		D.O.B/ Age:		D.O.A.:	
Primary Language:		Gender:		Race:	
M.A. Recipient #:		Religion:			
Other Insurance #:		Soc. Sec.(last 4):			
Marital Status:					
Citizenship Status:		Hair Color:		Height:	
Place of Birth:		Eye Color:		Weight:	
Type of Placement:		Legal Status:	◯ Dependent ◯ Delinquent ◯ Parent Rights Terminated ◯ CYS ◯ Probation		
Distinguishing Marks/Features:					

IL WORKER INFORMATION:

Name:		Name of 2nd Adult:	
Address:		Home Phone #:	
		Work Phone #:	
		Cellular/Pager #:	
County of Residence:		Other #:	

FAMILY/GUARDIAN INFORMATION:

Name:		Name:	
Address:		Address:	
Home Phone #:		Home Phone #:	
Work Phone #:		Work Phone #:	
Other #:		Other #:	
Involvement:		Involvement:	

EMERGENCY CONTACT INFORMATION:

In emergency, contact:		Referring Agency:	
Address:			
		Case Manager Name:	
		Address:	
Home Phone #			
Work Phone #:		Office Phone #:	
Other #:		Agency Emergency #:	
Relationship:		County Crisis #:	

Note:

OTHER AGENCY/ADVOCACY INVOLVEMENT:

Name:		Name:	
Agency:		Agency:	
Address:		Address:	
Work Phone #:		Work Phone #:	
Other #:		Other #:	
Involvement:		Involvement:	

BEYOND FAMILY LIVING, INC.

MEDICAL: **MEDICAL SECTION *MUST* BE COMPLETED**

Medical Conditions/Special care required:	Dietary Restrictions:
Allergies:	Physical Limitations:

MEDICATIONS: **MUST BE COMPLETED, IF CHILD IS CURRENTLY TAKEN MEDICATION (PLEASE PROVIDE 1-2 WEEKS SUPPLY.)**

Name of Medication	Dosage	Times Given	Prescribing Dr.	Reason for Med
Is Individual self-medicating? Pharmacy Name and Phone #:				

DSM IV INFORMATION:

Axis #	Code #	Diagnostic Name

REASON FOR PLACEMENT/BRIEF HISTORY:

**Please list any previous hospitalizations and events leading to placement with Beyond Family Living.

BEHAVIORS/PRECIPITANTS (CS) OR SPECIAL NEEDS AREAS (MR/DD):

** Please identify all high-risk behaviors (i.e. history of elopement, sexual aggression, suicide, fire setting, etc.)

RESPITE INFORMATION:

The following information/exclusions should be considered for respite:

☐ No Children	☐ No Young Children	X No pets
☐ No Older Children	☐ No Adolescents	☐ No Opposite Sex Peer
☐ No Same Sex Peers	☐ No Cross-Cultural Homes	X Non-Smoking Home
☐ No Homes near pools Or Bodies of water	☐ Wheelchair Accessible	☐ One Story/ranch home

* Other matching criteria.

Please list: _____

* Children's Services: Any restrictions on phone calls/visits? _____

* Name and phone # of regular respite provider:

INTERVENTIONS:

WHAT WORKS:	WHAT HAS NOT WORKED:

** EMERGENCY PLAN FOR BEHAVIOR(S), including special instruction to the Mentor/the Individual.

** SAFETY PLANS FOR INDIVIDUALS (ambulation, fire, heat sources, PICA, etc)

SUPERVISION:

LEVEL OF SUPERVISION REQUIRED BY THE INDIVIDUAL (ABILITY TO PROTECT SELF AS PER ISP/IPP. For example, alone time (list amount of time), bathing (assess safety awareness).	
Home: _____ Bathing: _____	Community: _____ Pools/Water: _____
* Special bathing instructions: (i.e. water temperature)	* Special provisions for supervision around water: .

VOCATIONAL/DAY PROGRAM/SCHOOL:

Name: _____ Address: _____ _____ Division/Grade: _____ Transportation: . (Name, Bus #)	Contact Person: _____ Telephone Number: _____ Transportation Telephone Number:

CASEWORKER INFORMATION (If different from above):

Agency Name: _____ Address: _____	Caseworker Name: _____ Telephone Number: _____

IMPORTANT TELEPHONE NUMBERS AND ADDRESSES

Please list the following information. Write N/A if a provider is not needed in a certain category.

PROVIDER	NAME	ADDRESS	TELEPHONE #

Please list other relevant medical contacts below:

PROVIDER	NAME	ADDRESS	TELEPHONE #

Children's Services: Any restrictions on phone calls/visits? ☐ Yes ☐ No If Yes, please advise restrictions and copy of court order. _____

_____

_____

Email completed form to: management@beyondfamilyliving.org Subject: New Referral

Caseworker

Signature: _____ **Date:** _____

***** Please ensure that all sections of this form is completed. submitting an incomplete form may delay the placement process.**

****

To Be Completed by Pathway to Everyday Life:

Admission Accepted: ☐ Yes ☐ No **Admission Date:** ____/_____/_____

Comments:

PDC PHARMACY PHILADELPHIA
INFORMATION NEEDED FOR NEW INDIVIDUAL

Individual Specific Information

- **Agency:** _____
- **Full Name of Resident:** _____
- **Address at which the Individual Resides:** _____

  _____
- **Phone Number:** _____
- **Sex:** **Male** ☐ **Female** ☐
- **Date of Birth:** _____
- **Social Security Number:** _____
- **Expected Date Consumer Arriving:** _____
- **Is Consumer Coming With Medications or Are Medications Needed ASAP?:** _____
- **Previous Pharmacy Name & Phone #:** _____
- **Primary Care Physician Information If Applicable:**
  - **First/Last Name & Phone Number:** _____
- **Diagnosis:** _____

  _____
- **Allergy Information:** _____

  _____
- **Diet Information:** _____
- **Agency is Representative Payee (Guarantor):** **Yes** ☐ **No** ☐
  If no, please provide the Name, Address, and Phone Number of the responsible person:
  - **First and Last Name:** _____
  - **Address:** _____

    _____
  - **Phone:** _____
- **Does the resident attend a day program?** **Yes** ☐ **No** ☐
  If yes, please select the days of the week attended and enter the times of attendance:
  ☐ **Monday** (__-__) ☐ **Tuesday** (__-__) ☐ **Wednesday** (__-__) ☐ **Thursday** (__-__) ☐ **Friday** (__-__)
- **Please note any religious beliefs or cultural background that impact the patient's lifestyle and/or view of healthcare that will need to be considered by PDC Pharmacy when providing care**

  _____
- **Please attach Copies of all Insurance Cards (Include Medicare Card if applicable)**
- **Please include a copy of the current MAR for the individual.**

PDC Pharmacy

PATIENT AUTHORIZATION AND PLAN OF SERVICE

Patient Name: _____ ID_____

Insurance payment authorization: I request that Medicare and/or any other insurance plan that I have to make payments of authorized benefits on my behalf directly to PDC Pharmacy for pharmaceuticals that were furnished to me for which they bill Medicare and/or any other insurance plan on my behalf.

Release of insurance information: I request my medical insurance plan(s) to release to the above named pharmacy, any and all information which will assist in processing my claims for pharmaceuticals that I am receiving from the above named pharmacy even after service to me is discontinued. I also authorized any holder of hospital or medical information about me to release to the health care financing administration, its agents, my insurance company or the above named pharmacy any information needed to determine the benefits that are payable for related services.

I understand if my insurance plan(s) makes payment(s) to me for pharmaceuticals that I have received, rather than directly to the above named pharmacy, I agree to endorse those checks and send them immediately to the above named pharmacy.

I also understand that I am responsible for the payment of any deductible, co-insurance or other portion of my charges not paid by my insurance plan(s). I also understand that I may be eligible for a partial or complete waiver of any unpaid co-insurance charges only, under PDC Pharmacy financial hardship program.

_____ **(Initials) I acknowledge that I have been advised of my financial obligations to PDC Pharmacy including copays, deductibles and any anticipated denials for products furnished by PDC Pharmacy**

I hereby agree that PDC Pharmacy or any of its affiliates may contact me, or my authorized caregiver, by telephone at my place of residence.

I have reviewed and understand the information above. I have been instructed on and understand the use of the products provided. I have received the products ordered. I have received a copy of a patient handout that contains, patient rights and responsibilities, privacy standards, emergency planning, making decisions about your health care, grievance/complaint information and drug information. I have received monograph/instructions for medications received. I have received pharmacy marketing material and information on the pharmacy's scope of services. I have received instructions on how to follow up with PDC Pharmacy

I understand that prescribed pharmaceuticals cannot be re-dispensed. Therefore, these items cannot be returned for credit.

I understand that I may lodge a complaint without concern for reprisal, discrimination, or unreasonable interruption of service.

Identified needs/problems: The patient may be unfamiliar with use of the pharmaceuticals provided. Expected outcomes: The patient will be provided the pharmaceuticals to comply with the physician's prescription. The patient will use the pharmaceuticals as prescribed by the physician. The patient will know how to obtain follow-up services as needed.

PATIENT OR RESPONSIBLE PARTY SIGNATURE: X_____ DATE:___/___/____

PATIENT OR RESPONSIBLE PARTY

PRINT NAME: _____

IF BENEFICIARY IS UNABLE TO SIGN:_____

WITNESS SIGNATURE / RELATIONSHIP:_____

REASON PATIENT UNABLE TO SIGN:_____

Please return the Patient Authorization and Plan of Service Form to PDC Pharmacy Thank you for choosing PDC Pharmacy

Form Revised: 06/01/2017

BEYOND FAMILY LIVING

"Where We Treat You Like Family"

AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

This form is being submitted for the release and/or exchange of confidential information including but not limited to: medical, dental, educational, and psychological documents pertaining to _____, who was placed at Pathway to Everyday life group home on _____until _____. This information is being used for the coordination of services and well-being of the aforementioned child.

I, _____, legal guardian and/or custodian of _____

authorize Beyond Family Living, Inc. to:

☐ release to:
☐ obtain from:
☐ exchange with:_____
_____

_____

_____

The following information pertaining to _____:

☐ Education Records / IEP
☐ Treatment Summary
☐ Dates of Treatment Attendance
☐ History / Intake
☐ Diagnostic
☐ Psychological Test Results
☐ Psychiatric Evaluation / Medication History
☐ Medical / Medication History

For the purpose of:

☐ Intake / Placement into the facility
☐ Evaluation / Assessment and/or Coordinating Treatment Efforts

This consent will automatically expire one (1) year after the date of my signature as it appears below, or on the following earlier dates, conditions, or event _____.

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except that the information has already been released).

_____ Social Security #: _____Date of Birth _____
Signature & Date of Caseworker/Parent/Legal Guardian

_____ _____
Staff Signature/Title Date

2716 Manor Drive NE * Palm Bay, FL 32905 * Tel.: (484) 206-4477 * Fax: (484) 214-0088
www.beyondfamilyliving.org

2716 Manor Drive NE Palm Bay FL 32905
Phone: (484) 206-4477; Fax: (484) 214-0088

MEDICAL / DENTAL AUTHORIZATION

Authorization is hereby given to:

Beyond Family Living
Name

2716 Manor Drive NE Palm Bay, FL 32905
Address

484-206-4477
Area Code / Telephone Number

To obtain routine and emergency medical and dental treatment for _____
Date of birth _____.

This authorization does not include non-routine, non-emergency treatment such as non-emergency surgery, cosmetic surgery, or experimental procedures or treatment.

The above names child/youth is in the legal custody of _____
and is in placement with the above-named provider, pursuant to Florida Department of Children and Families.

_____ _____
Caseworker/Legal Guardian/Parent Date

_____ _____
Staff Signature/Title Date

BEYOND FAMILY LIVING

"Where We Treat You Like Family"

CONSENT TO TREAT MINOR CHILDREN

I, _____, parent or legal guardian of

_____(child's name), Age: _____, born _____/_____/_____, **do hereby consent** to any medical and/or dental care and the administration of anesthesia determined by a physician to be necessary for the welfare of the child while said child is under the care of **Beyond Family Living, Inc.** and I am not reasonably available to give consent.

This authorization is effective from:

Date of Admission: _____/_____/_____ to **Date of Discharge:** ____/_____/_____. (3800.241 (b) 3)

_____ _____

Resident/Child Name Signature Date

_____ _____

Caseworker/Legal Guardian/Parent Date

_____ _____

Staff Signature/Title Date

Additional information to assist in treatment

Family Address: _____

Telephone: _____

Father: _____Home: _____Work: _____

Mother: _____Home: _____Work: _____

Last Tetanus: _____

Allergies to drugs or food:

Special Medications, Blood Type or Pertinent Information:

Child's Physician: _____Phone: _____

Insurance: _____**Policy #: _____**

Preferred Hospital: _____

Copy of the child's most recent health examination is attached.

****Take this consent form with the child to the hospital in an emergency or physician's office when the child is taken for treatment****