PADTC Referral Process

From Inquiry to Referral

For Pre-Screening call PADTC and speak with the Clinical Director. Inquiry calls welcome from Families, School Counselors, Community Professionals, Probation Officers, and others.

Clinical Director: Richard W. Brown, LCSW

503-623-5588 ext. 103

503-623-4729 FAX

rwb@padtc.org

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From Inquiry to Referral

► Determine funding sources and service options:

Funding Source:

If student qualifies for OHP – Apply to New Solutions
MARION COUNTY NEW SOLUTIONS – 503-361-2724
LINN COUNTY NEW SOLUTIONS – 541-967-3866
POLK COUNTY NEW SOLUTIONS – 503-623-9289
TILLAMOOK COUNTY NEW SOLUTIONS – 503-842-8201
YAMHILL COUNTY NEW SOLUTIONS – 503-434-7462

School Funded students who do not qualify for OHP.
PADTC currently has students funded by Dallas, Central, Woodburn, McMinnville, and Perrydale School Districts

Private Insurance.
Call PADTC (503) 623-5588 to discuss insurance eligibility and guidelines as required by your own insurance company.

Self-Pay.
Call PADTC (503) 623-5588 to make arrangements and agreements.

Serving children and families in the community since 1980…

► Service Options:

Psychiatric Day Treatment
45 Day Assessment and Evaluation
Outpatient Services

► Once Referral is Made:

Intake information starts to be gathered
Intake staffing scheduled with community professionals; Held at PADTC
Family assessment with clinical director (this can happen at anytime in the intake process)
½ day visit
Decision is made by team
Preliminary family meeting with PADTC therapist, start date is determined.

What services are provided in Psychiatric Day Treatment?

► Individual Therapy (master's degree level therapist)

► Group therapy (3x's per week)

► Family therapy (weekly)

► Structured milieu therapy (the basic premise is that "therapy" can and does happen in any environment; whether it is in the therapist office, hiking in the woods or riding in a van)

► Emphasis on a cognitive/behavioral model which incorporates numerous points systems, incentive plans, and problem solving tools

► Utilize principles of collaborative problem solving

► Social skills training

► Stress management

► Activities therapy (play, art, equine)

► Applied arts program (this includes options such as gardening, guitar, computer keyboarding, drama, scrapbooking, office skills, art, creative writing, and pottery)

► Individualized Education Plan for each student in a small classroom setting (4:1 student/staff ratio which includes 2 master level teachers)

► Psychiatric consultation

► Consultation/coordination of services with involved community members (schools, juvenile department, physicians, therapist, clergy, DHS caseworks, etc.)

► Transition services (back to public school or appropriate placement)

► Outpatient services for kids/families prior to admission is available.

► Outpatient services for kids/families following termination of day treatment is available.

30 - 45 Day Initial Evaluation Period

When a student and their family first enters the Polk Adolescent Day Treatment Center (PADTC) the initial 30 – 45 days is considered an evaluation period. This period offers both the family and PADTC staff an opportunity to evaluate whether or not the program really is a good fit to meet the needs of the student.

The type of questions that typically will be addressed may include:

- Are the structure and the expectations at PADTC a helpful fit?
- Is the student receiving adequate support to meet their needs?
- Does the student feel safe?
- Is the student able to be at PADTC in a safe manner?
- Is the student able to attend PADTC on a regular basis in order to take advantage of what the program has to offer?
- Is the family making it to family meetings on a regular basis?
- Is the family participating openly during family therapy?

As a team we will review these types of questions on a quarterly (every 3 months) basis to determine if PADTC continues to be the best choice to meet the need of the student and the family.

COMPLETION CHECKLIST

Please check each item when completed and include with the application material. It is helpful to send all the material at one time to assure a quicker process.

- ❑ Psychosocial History:

  To be completed by a mental health professional, agency personnel, school counselor, etc. A separate history is unnecessary if it is included in another current professional report.

  1. Pertinent family history
  2. Significant experiences in child's life, including relationships with siblings and parents
  3. Treatment resources previously utilized
  4. Student and family's present attitude toward the referral

- ❑ Psychiatric/Psychological Evaluations or Mental Health Assessment:

  Current psychological evaluation must be within the last 18 months and should include a DSM –IV five axis diagnosis.

- ❑ Medical Information:

  Pertinent medical history including current limitations, allergies, handicaps, medications and other information that may be helpful.

- ❑ Release of Information to PADTC,

  Sign and Date

- ❑ Pre-PADTC Data Forms

  These forms are included in this packet

  1. School Information
  2. Contact Information
  3. Medical Information

► School Information

IMMUNIZATION RECORDS _____

CURRENT IEP FORMS: ED & other handicapping conditions, eligibility & justifications; Physicians Statements; Supporting Documentation and all forms that apply.

- _____ R Parent Notification for Special Education Referral
- _____ R Current IEP
- _____ R1 Prior Notice and Consent for Evaluation (Initial or Reevaluation)
- _____ R60 Current Eligibility Paperwork
- _____ R13 Medical Statement or Health Assessment
- _____ R14 Prior Notice and Consent for Initial Placement into Special Education
- _____ R15 Notice of IEP
- _____ R16(1) IEP Any Assessment for Current Eligibilities
- _____ R18 Prior Notice of Special Education Action
- _____ R19 Permission to Release/Exchange Information
- _____ Any other Certifications/Eligibilities

OTHER INFORMATION

Please include any available information from other resources, including but not limited to; Juvenile Records, Outpatient information summaries, psychologist and psychiatric evaluations.

► GENERAL INFORMATION

STUDENT:

Legal Name: ____

Student likes to be called: ______________________________________

Date of Birth ________________________ Sex _______ Race* ________________

PARENT OR GUARDIAN:

Name: ____ Age: ________

Address: _____________________________ City ______________ Zip: _________

Phone Numbers:

Home: __________________ Work: _______________ Cell: ______________

Name: ____ Age: ________

Address: _____________________________ City ______________ Zip: _________

Phone Numbers:

Home: __________________ Work: _______________ Cell: ______________

SCHOOL CONTACT:

Name: ____

Address: _____________________________ City ______________ Zip: _________

Phone Numbers:

Work: _______________ Cell: ______________

Briefly describe why this student and family are considering PADTC:

*Note: this is for statistical purposes only

▶ MEDICAL DATA INFORMATION

(To be completed by physician)

Is the patient currently under the care of a medical doctor, including a Psychiatrist?

Patient's Name: ______________________________ DOB: __________

Physician: ______________________________ Phone: __________

Date of patient's last physical exam: ________________

Significant Findings: ____

____

Is patient taking any prescribed medication? ☐ Yes ☐ No

Please Explain: ____

____

What is the general condition of patient's health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Incapacitating

Which, if any, of the following is a problem?

☐ Overweight ☐ Alcohol/Drug Use ☐ Exercise ☐ Other

Please Explain: ____

____

What are the main findings of this examination: ________________________

____

____

Does the patient have a physical limiting or disabling condition? ☐ Yes ☐ No

Please Explain: ____

____

To what extent is performance or activity in school likely to be affected?

____

Any further test or referrals indicated? ______________________________

____

______________________________ ______________

Physician Signature Date

► Private Insurance Questionnaire

Date: ____________

Client's Name ______________________________ Client's Date of Birth ______________

Diagnosis Code _______________________________ Gender: ☐Male ☐Female

Insured's Name ______________________________Insured's Date of Birth _____________

Insured's Address _____________________________City __________State_____Zip______

Home Phone ________________Cell Phone_________________ Sex ☐Male ☐Female

Insured's Policy Group # _________________I.D.# ____________________

Employer's Name _________________________ Insurance Plan Name________________

Is There Another Insurance Plan? ☐Yes ☐ No

If yes, complete the following:

Other Insured's Name ________________________Other Insured's Date of Birth ________

Other Insured's Address: ________________________City___________State_____Zip______

Home Phone ____________Cell Phone________ Gender ☐Male ☐Female

Other Insured's Policy Group # _________________I.D.# ______________________

Employer's Name _______________________ Insurance Plan Name________________

Copy of Insurance Card ☐yes ☐no Prior Authorization #______________________

(If applicable)

***INSURED'S OR AUTHORIZED PERSON'S SIGNATURE** I authorize release of any medical or other information necessary to process claims by the undersigned provider. I also authorize payment of medical benefits to the undersigned provider for services. This information may be given to a 3rd party billing service. By signing you approve AMH Physician Billing Inc. to bill for services rendered.*

SIGNED ______________________________________ DATE _______________

SERVICE/BILLING ADDRESS 2200 E ELLENDALE

CITY DALLAS **STATE** OR **ZIP** 97338 **PHONE** 503-623-5588 **FAX** 503-623-4729

FEDERAL TAX I.D. NUMBER ____________________ **NPI #** ______________________

THERAPIST NAME ____________________________TITLE/DEGREE _________ DATE________

(First, M.I., Last)