WMC Health | HealthAlliance Hospital
Westchester Medical Center Health Network

HealthAlliance Hospital
105 Mary's Avenue
Kingston, NY 12401
845.338.2500
HAHV.org

Adolescent Partial Hospitalization Program Referral Form

Adolescent Partial Hospitalization Program
105 Mary's Avenue, Kingston, New York 12401
Telephone: 845-334-3110 Fax 845-334-4972

The Adolescent Partial Hospitalization Program (APHP) is a voluntary, intensive, short-term multi-disciplinary psychiatric treatment program for adolescents. Individuals who are admitted must be at risk of psychiatric hospitalization or be transitioning from an inpatient stay to the community. APHP is designed in compliance with NYSOMH and DNV standards to provide alternative to inpatient treatment for persons with acute symptoms, meeting medical necessity criteria, who can be safely treated with less than 24 hours of daily care.

The major treatment focus is symptom reduction and the acquisition of coping skills through group therapy. Dialectical Behavior Therapy is the main treatment modality. A psychiatric provider manages medication and directs the treatment team. Mental health clinicians provide supportive individual therapy, group therapy, family therapy, case management, and advocacy.

Patient must be between the ages of 13 and 18, appropriate for the milieu and willing to attend program 8:00am to 2:00pm, Monday through Friday for a period of approximately three weeks. Child must be escorted by parent/legal guardian to the intake appointment. **If patient is being escorted by guardian, legal guardianship paperwork must be provided. See checklist page**

Please sign and date after completing all information indicating verification that admission criteria has been satisfied prior to faxing referral and supporting documentation to PHP for review.

Name of patient:_____ DOB:_____ SS#:_____

Address:_____,_____,_____,_____
Street City State Zip Code

Patient cell phone or none: _____

Parent/Legal Guardian: _____,_____,_____
Name Relationship Phone #

Referring Provider & Agency :_____ Phone #:_____

Outpatient Therapist & Agency or none:_____ Phone #:_____

Current Psychiatrist & Agency or none:_____ Phone #:_____

Current Medications, if applicable: (If needed, attach copy of current MAR or Medication History sheet)

_____

Significant medical concerns. Yes / No Comments: _____

***Verification of Medicaid or Private Insurance Benefits for PHP and access to medications is REQUIRED.**

Medicaid CIN# _____

Insurance Type:_____ ID#_____

Insurance Co. Phone #_____ Copay _____ Co-insurance _____

Deductible (due at time of referral)_____ Out of Pocket Max _____

Preauthorization Information (Inpatient Referrals Only): Authorization # _____

Date Authorized_____ Insurance Representative Name_____ Phone #_____

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Describe current symptoms/behaviors of concern/reason(s) for referral:_____

_____

_____

Psychiatric disorder(s) to inform the major focus of treatment meeting medical necessity criteria: _____

_____

Patient's IQ (must be 70 or above): _____ School patient is registered with:_____

A stable residence within safe daily commuting distance of PHP is required. Current residence/reasoning if other than own home:_____

Does patient have access to reliable transportation? Yes / No (circle one) If no, does patient have medicaid insurance? Yes / No (circle one)

Type of transportation to be used: _____

****DBT treatment requires that a person <u>NOT</u> be under the influence of illegal substances. 15 days of sobriety, co-occurring substance abuse treatment, and random urine drug screens are expected. Use of illegal substances or non-compliance may result in discharge from the program.**

Patient's substance abuse history or none: (supported by toxicology reports, if available)

Date of last use:_____ Substance(s) used:_____

Recent history of violence directed at others: Yes / No (circle one) Comments / justification for referral:_____

_____

Recent history of self-harm and willingness to contract for safety: Yes / No (circle one) Comments / justification for referral:_____

History of sexual aggression, victimizing or serious criminal behavior including domestic violence or stalking: Yes / No (circle one) Comments / justification for referral:_____

_____

Supports: Family, Friends, AA, NA, case management, peer/family advocate, mentorship program, PINS, and any other supports, please indicate: _____

Parent/legal guardian and patient have been informed by referent that APHP is a voluntary program and that admission to APHP is not a pre-requisite for hospital discharge. Yes / No (circle one)

Referent Signature / Title: _____ / _____ / _____

Signature Print Name Date

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Adolescent Partial Hospitalization Program Referral Form Checklist

Please make sure to include all of the following when submitting a referral packet to the Adolescent Partial Hospitalization Program.

_____ Consent for release of information

_____ Completed 2-page PHP Referral Form

_____ Copy of insurance card *Very important* unable to review referral without this

_____ Most recent clinical progress note

_____ History & Physical and/or Psychiatric Evaluation (for hospital or clinic discharges)

_____ Demographic/Face Sheet (for hospital discharges)

_____ Discharge instructions (for hospital discharges)

If relevant/available:

_____ Consults, if any

_____ Labs/diagnostic studies

_____ Biopsychosocial assessment

_____ Last physical exam from PCP

_____ Psychological testing

_____ Legal guardianship paperwork (signed by judge)