HealthAlliance
Westchester Medical Center Health Network

Partial Hospitalization Program Referral Form

Adult Partial Hospitalization Program
105 Mary's Avenue, 2nd Floor Administrative Services Building
Kingston, New York 12401
Telephone: 845-334-3120   Fax: 845-334-4835

The Partial Hospitalization Program (PHP) is a voluntary, intensive, short-term, multi-disciplinary psychiatric treatment program for adults. Individuals who are admitted must be at risk of psychiatric hospitalization or be transitioning from an inpatient stay to the community. The PHP is designed in compliance with national A.A.B.H. standards and federal Medicare regulations 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 cognitive-behavioral group therapy. Dialectical Behavior Therapy is the main treatment modality. A full time psychiatrist is on the treatment team and mental health clinicians provide supportive individual therapy, case management and advocacy.

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

Name:______________________________ DOB:_________________ SS#:____________________

Address:______________________________, ______________________, ____________, ___________
PO or Street   City   State   Zipcode

Telephone:______________________ Cell:__________________

Emergency Contact:_________________________, ______________________, ____________________
Name   Relationship   Telephone #

Outpatient Provider/Agency:____

Referring Provider:_____________________________________ Telephone:_______________________

Current Psychiatrist:____________________________________ Telephone:_______________________

Current Medications: (If more than 12, attach copy of current MAR or Medication History sheet)

____ ____

____ ____

Allergies: ____

****VERIFICATION of MEDICAID or PRIVATE INSURANCE BENEFITS for Partial Hospitalization Program (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: Authorization#________________ **Dates Authorized**____________
(Inpatient Referrals Only)   **Insurance Representative** Name ___________ Phone #________________

Current Symptoms: ____

____

____

Axis I Psychiatric Disorder that is the major focus of treatment meeting medical necessity criteria.
DX: ____

Recipient must be at least 18 years of age, appropriate for the milieu and willing to attend: 9:30am to 3: 30pm, Monday through Friday for a period of approximately three weeks. Proposed plan of treatment:

____

A Stable residence within safe daily commuting distance of PHP is required. Current Residence if other than own home:____LOS:___________

Access to reliable transportation and telephone communication: (own car, cab, bus, rural transportation)
Type of transportation to be used: ____

Is the patient receiving public assistance? ____YES ____NO Applied?___YES ____NO Date:____________

****DBT requires that a person NOT be under the influence of un-prescribed substances. Therefore, 15 days of sobriety, co-occurring substance abuse treatment and random urine drug screens are expected.**
Non-compliance may result in discharge from the program.

Substance abuse history: (supported by toxicology reports, if available)
Date of last use:________________________________ Substance(s) used:________________________________

____

No recent history of violence directed at others and a willingness to contract for safety and refrain from self-injurious behavior. Comments:____

____

No history of sexual aggression, victimizing or serious criminal behavior including domestic violence or stalking: Comments;____

____

Supports: Family, Friends, AA, NA, ICM, SCM and any other supports, please indicate: ____________________

____

Patient has been informed that PHP is a voluntary program and that admission to PHP is not a pre-requisite for hospital discharge. Comments:____

____

Referent Signature/Title:_________________________ _______________________ ___________ ___________

	Signature	Print Name	Date	Time

Referring Facility____________________________________Telephone#:____________________

Approved by Document Control 2/2018