Hello,

Thank you for considering Bestwood Agency Intensive Residential Treatment services. While we understand that the referral and screening process is extensive and time consuming, this is to ensure that our team provides the best services possible. The referral process is a joint activity with the client, the client's current treatment providers, any members of the client's natural support network identified by the client, and members of our team. This referral packet includes:

- A referral information form to gather information about the individual which includes requested documentation to assist in determining eligibility for services as outlined in Minnesota Statute 245I.23, Subd. 15.
- Information about Bestwood Agency IRTS as well as program expectations to help you make an informed decision about your treatment.
- A blank release of information to assist in care coordination and the referral process.

Supporting documentation that is necessary to aid in successful placement of an individual includes but is not limited to:

- Current diagnostic assessment, psychiatric evaluation, and/or functional assessment
- Most recent treatment plan and progress notes
- Current list of medications

A full list of required documentation can be found on page 3. In addition to the above documentation, an interview may be completed with the individual to ensure they meet all criteria necessary for a safe and successful placement. After a candidate is successfully screened and accepted, a source of payment needs to be secured prior to admission. We also require signed medication orders from the prescribing physician as well as 30 days of medications prior to admission.

Please let us know if you have questions or need assistance navigating our referral process.

Email: info@bestwoodagency.com
Phone: (320)774-1187

Please send completed referral information and supporting documentation to:
Fax: 320-774-1188
Email: info@bestwoodagency.com

Sincerely,

Noor Yussuf, CEO
Bestwood Agency, LLC

Client Information			
Client Name		Date	
Date of Birth		Phone Number	
Sex		Gender Identity	
Social Security Number		Pronouns	
Current Address			
Current Location			
Preferred Date for IRTS Admission			
Diagnosis			
Type of Commitment	☐ MI ☐ MI/CD ☐ MI & D ☐ Jarvis		
Guardianship / Legal Status			
Case Manager (If different than referral source)		Phone	
County of Financial Responsibility			
Monthly Gross Income		Income Source	
Community Psychiatric Provider			
Therapist			
ARMHS Worker			
Probation Officer		Agency	Phone

Benefits
☐ MA ☐ MA Pending ☐ SMRT Pending ☐ Soc Sec Pending ☐ GA ☐ Waiver ☐ RSDI ☐ SSI

Insurance			
Name of Plan		Type of Plan	
Plan ID/PMI			
R&B Contribution to IRTS, If Any		Client Agrees	

Referent's Contact Information			
Name of Referral Source		Phone Number	
Email Address			

Goals for Placement

Additional Information Relevant to IRTS Placement (support system, cultural consideration, spiritual needs, medical needs, etc.)

The following supporting documentation must be included with this referral form. Please check all that is included:

- ☐ Releases of information for all current providers
- ☐ Current Assessments
  - ☐ Diagnostic Assessments
  - ☐ Psychiatric Assessments
  - ☐ Functional Assessments
- ☐ Current Medication List
  - ☐ Medical history and current medical needs
- ☐ Treatment Plan & Crisis Plan
- ☐ Other relevant treatment documents
  - ☐ Verification of health insurance
  - ☐ Financial/Benefits information
- ☐ Legal documentation: Civil commitment paperwork/Probation requirements (if applicable)
- ☐ Guardianship/Conservatorship documentation (If applicable)

THE FOLLOWING INFORMATION WILL BE REQUIRED PRIOR TO INTAKE

☐	If client is on a stay of commitment or full commitment, a copy of the court findings which indicate the type of commitment as well as provisional discharge requirements. If there is a Jarvis order, copies of the order are also required.
☐	30-day supply of medication and signed orders from the attending physician for all prescribed medications. Also, any medications required **prior authorizations** need to be completed and approved prior to facility admission.

Please send completed referral information and supporting documentation to:
Fax: 320-774-1188
Email: info@bestwoodagency.com

Admission determinations will be made within 72 hours of receiving all pre-admission materials pursuant to Minnesota Statute 245I.23, Sub. 17

Phone: 320-774-1187
Fax: 320-774-1188
info@bestwoodagency.com
www.bestwoodagency.com
1506 33rd Ave N
St. Cloud, MN 56303

Authorization for Disclosure of Health Information

Client Information	Client Name: _____ Date of Birth: _____ Previous Name(s): _____ Address: _____ Phone #: _____ City: _____ State: _____ Zip Code: _____ E-mail Address (Optional): _____	
I Authorize	**Bestwood Agency LLC** To do the following: ☐Release To ☐ Receive From ☐Both Release & Receive	Contact Name/ Department: _____ Agency Address: City/State/Zip Phone
With	Agency/ Name: _____ Phone #: _____ Address: _____ Fax #: _____ City: _____ State: _____ Zip Code: _____ E-mail Address (Optional): _____	
What do you want released?	☐Record Dates between: _____ to _____ ☐Verbal ☐Diagnostic Assessment/ DA Update/ Comp Eval ☐Progress Notes ☐Treatment Plans ☐Functional Assessment/DLA 20 ☐ Psychiatric Eval ☐Medication Notes ☐Psychological Eval ☐Summary of Services ☐School Records ☐Screening Tools ☐Social Services ☐Benefits/ Financial ☐Legal/ Court/ PO ☐Billing Records ☐Other: _____	
Purpose of Release	☐ Coordination of Care ☐Client Request/ Personal ☐Legal/ Court ☐Insurance Company ☐Financial/ Billing ☐Family Request ☐PCP Letter ☐Other (Please Specify): _____	
Substance Use Disorder (SUD) Special Consent	Per Federal Rule 42 CFR, part 2 this section must be completed to release SUD records. ☐Dates of Service is REQUIRED between: _____ to _____ ☐ SUD Assessment ☐SUD Weekly Summary Notes ☐SUD Discharge Summary ☐ Monthly Tx Plan Review ☐SUD Verbal ☐Other: _____	
Preferred Method	☐Mail ☐Fax ☐E-mail ☐Pick-Up	
Authorization	This authorization will expire one year from the date of the signature below unless there is a different date/event indicated on the right. Client Signature: _____ Expiration Date: Date: _____ I am signing as an authorized representative of the client, I am: ☐ Parent of a Minor ☐ Court Appointed Guardian/ Conservator Parent/ Guardian Signature: _____ Date: _____	

Disclaimer: Bestwood Agency LLC may not condition my treatment, payment, enrollment, or eligibility for benefits by signing this authorization. Bestwood Agency LLC cannot prevent the re-disclosure of records released because of this request, and after information is released from Bestwood Agency LLC, the records may not be subject to the Federal Privacy Rule Laws. SUD Records- The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person whom it pertains or as otherwise permitted by 42 CFR, part 2. A photocopy of this authorization will be treated in the same manner as the original. I have the right to revoke this authorization at any time by giving written notice to Bestwood Agency LLC. I understand that the revocation will not apply: 1) to information that has already been released in response to this authorization, or 2) to my insurance company as the law provides my insurer with the right to contest a claim under my policy.

Guidelines for Completing the Bestwood Agency LLC Authorization for Disclosure

Client Information: Complete this entire section with clear and legible writing so the information identifies the client whose information is being requested/ released.

I Authorize: Please check by either: 1) Release To, 2) Receive From, or 3) Both Release & Receive. If you choose only "Release To" Bestwood Agency LLC can only share information; If you choose only to "Receive From" Bestwood Agency LLC CANNOT share any information; If you choose "Both Release & Receive" Bestwood Agency LLC may share and receive information from the agency/ name listed on the form.

With Agency/ Name: Indicate clearly and legibly where or whom you wish to send/ receive information with. Be as specific as possible.

What do you want Released? The purpose of this section is to have us share the information you want us to. Only the specific information checked will be released. If no dates are specified, we will only release the most recent DA and 3 progress notes. Minimum Necessary means we will use the least amount of information possible to accomplish the desired task. Select "Verbal" if you want us to release or obtain information verbally with the listed releasing/ obtaining party. Verbal is all inclusive. "Screening Tools" will include: SDQ/ CBCL, PHQ-9, and Locus.

Purpose of the Release: Identify the reason you need to release/ request information. This helps Bestwood Agency LLC appropriately provide care and track releasing of confidential information. It informs us who may be responsible for the cost of medical records being released and is required on each release. *Fees may be charged in accordance with MN statutes 144.292 and Federal Rule 45 CFR 164.524 (where applicable).

Substance Use Disorder (SUD) Special Consent: This section must be completed to allow previous agencies to release SUD records on your behalf. This information is protected by Federal Confidentiality Rules (42 CFR, Part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person whom it pertains or as otherwise permitted by 42 CFR, part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. The dates of special consents are required to release SUD records. Select "Verbal" if you want us to release or obtain SUD information verbally with the listed releasing/ obtaining party. Verbal is all inclusive.

Preferred Method: This tells us how you would like your information provided. We can print and mail the documents, send them by fax, CONFIDENTIAL email, or we can print the records and make them available for you to pick-up at one of our locations.

Authorization and Revocation: Signing this form (or having the parent/ legal guardian sign for the client) will grant authorization to share/ receive confidential information. Please sign and date this form to validate this authorization. If signed by someone other than the client or parent of a minor, you will be required to provide written proof of your authority (legal paperwork). This authorization will automatically expire in one year from the date signed unless a different date or event has been identified, not to exceed 5 years per (144.293, Subd. 4) from the date signed. This authorization can be revoked at any time by your written request to Bestwood Agency LLC.

- You may only enter one entity, clinic, or individual per Release of Authorization of Disclosure.
- If requesting records, please allow 7-10 business days for processing of the Release of Information (ROI). In some cases, it can take up to 30 days (45 CFR 164.524(b)(2)(i).

Respecting Self

1. Residents are encouraged to attend all scheduled program groups and activities as part of their individual treatment plans.
2. We ask all our residents to take their medications as prescribed.
3. Borrowing money and other items between residents is prohibited.
4. Smoking and chewing tobacco are allowed outside in the designated area.
5. Any resident items left at Bestwood after discharge will be stored for no longer than 30 days, at which time, the items will be disposed of.
6. Passes: All passes will be reviewed as a team on a weekly basis. All passes must be submitted by Thursday morning at 8:45am to be considered for the upcoming week.
    a. Overnight pass requests may be requested and are usually reserved for the last 30 days of treatment so long as it is relevant to a discharge treatment plan, or for extenuating circumstances.
    b. Dinner passes may be requested but must be related to treatment plan goals, or there must be extraordinary circumstances.
    c. Visitor passes are available only on Sundays between 2:00-5:00pm to leave campus with a visitor.
7. Residents may have visitors at the facility Monday through Saturday between 4:00pm-5:00pm. On Sundays, residents can entertain visitors from 2:00pm-5:00pm.
    a. We ask that residents pre-arrange visits with facility staff 48 hours in advance to ensure that we have adequate space to accommodate on-site visitation.
    b. All visitors must sign a confidentiality agreement.
    c. No visitors are allowed in clients' bedrooms. All visits must take place in common areas such as the dining room or courtyard.
8. The use of alcohol, drugs, herbal supplements, nonprescribed mood-altering substances of any kind are prohibited on the premises.

Respecting Our Facility

1. We ask that residents refrain from dying their hair while in our facilities due to the mess and damage it may cause.
2. We ask that everyone honor confidentiality of our residents and visitors, and we expect that our staff will do the same.
3. Residents should not enter another resident's room.
4. We ask that individuals are fully clothed with appropriate footwear when outside of their individual bedrooms.
5. Violence, the threat of violence, or language that is abusive, discriminatory, or harassing in nature, will not be permitted.
6. For safety reasons, candles and incense are prohibited in the building.
7. Residents are responsible for keeping their space clean and cleaning up after themselves.
8. Sexual activity of any kind is always prohibited in the building.