Thank you for considering Bestwood Agency Intensive Residential Treatment services. While we understand that the referral and screening process can be extensive and time consuming, this helps us 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.

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.

The following list of items must be received at least 24 hours *prior* to admission:	
	Signed medication orders
	Signed routine standing orders form (attached)
	30-day supply of medications including insurance information sent to Genoa Pharmacy **If the client is a new patient of Genoa, the Genoa New Consumer Enrollment Form must be sent to Genoa*
	Signed ROI for the referral source

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			

Significant Required Information	
Mobility Concerns? If yes, please explain.	
Allergies? Please list.	
Special Dietary Needs?	

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

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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).

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www.bestwoodagency.com
1506 33rd Ave N
St. Cloud, MN 56303

Client Name: _____

DOB: _____

Allergies: _____

Routine Standing Orders

Please check the box next to medications authorized for administration.

☐ 1. Acetaminophen/Tylenol 500mg tablet: take 1000mg (2 tabs) by mouth every 6 hours as needed for fever/ minor aches and pains and cold symptoms; not to exceed 3000mg (6 tabs) in a 24-hour period

☐ 2. Ibuprofen/Advil 200mg tablet/capsule: take 200mg (1 tab/cap) by mouth every 4 hours while symptoms persist for headache/toothache/backache/menstrual cramps/common cold/muscular aches; not to exceed 1200mg (6 tabs) in a 24-hour period
the smallest effective dose should be used

☐ 3. Cough drops: take one and let dissolve slowly in mouth every 2 hours as needed for cough/sore throat

☐ 4. Tums/Calcium Carbonate 750mg chewable tablet: chew 2 tabs by mouth every 2 hours as needed for indigestion/heartburn/upset stomach; not to exceed 10 tablets in a 24-hour period

☐ 5. Loperamide/Imodium 2mg tablet: take 4 mg (2 tabs) by mouth at onset of first loose stool, take 2mg (1 tab) each subsequent loose stool; not to exceed more than 8mg (4 tabs) in a 24-hour period

☐ 6. Antibiotic Ointment/Bacitracin/Neosporin: apply lightly to affected area as needed

☐ 7. Milk of Magnesia: take 30mL by mouth once per day as needed for constipation

☐ 8. Hydrocortisone topical cream/ointment 1%: apply lightly to affected area as needed for itch and rash due to insect bites/eczema/psoriasis/inflammation/irritation/skin redness

☐ 9. Benadryl 25mg tablet: take 25 mg (1 tab) by mouth once daily for allergic reaction (i.e. rash/itching/hives/ swelling)
****If reaction includes breathing difficulties or is due to medication, call 911 IMMEDIATELY.****

☐ 10. Nicotine gum 2mg or 4mg: chew and park one piece every 1-2 hours as needed for nicotine cravings/withdrawals; not to exceed 12 pieces in a 24-hour period

☐ 11. Nicotine lozenge 4mg: take one lozenge and let dissolve slowly in mouth every 1-2 hours as needed for nicotine cravings/withdrawals; do not use more than 5 lozenges in 6 hours; not to exceed 12 lozenges in a 24-hour period

☐ 12. Melatonin 10mg tablets: take 1 tab just prior to or at bedtime to support restful sleep

☐ 13. Pepto Bismol Chewable tablets 262mg: chew or let dissolve 2 tabs every ½ hour (1 dose) as needed for nausea/heartburn/indigestion/upset stomach/diarrhea; do not exceed 16 tabs (8 doses) in a 24-hour period

☐ 14. OTC Cough and Cold Medicine (Dayquil or equivalent): take 30mL by mouth every 4 hours as needed for common cold symptoms, including nasal congestion, cough, sore throat, headache, minor aches and pains and fever; do not exceed 4 doses in a 24-hour period

☐ 15. Narcan 4mg nasal spray: standardized procedure for Naloxone Administration – see directions on box

☐ 16. First Aid Kit: OK to use as needed

Name of Clinic: _____

Provider Printed Name: _____

Provider Signature: _____ **Date:** _____

genoa healthcare

Consumer Enrollment Form

Section 1. Consumer/Facility Information

Consumer Name_____ Preferred Name _____
Last *First* *M.I.*

Social Sec. # _____ Date of Birth _____ Sex: M / F Preferred Pronouns _____

Mailing Address _____
Street *City* *State* *Zip*

Shipping Address_____
Street *City* *State* *Zip*

Email Address_____ Phone_____

Facility Name (if applicable)_____

Section 2. Acknowledgement of Receipt of Notice of Privacy Practices

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* of Genoa Healthcare, LLC. Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information. We encourage you to read it in full. Our *Notice of Privacy Practice* is subject to change. If we change our notice, you may obtain a copy of the revised notice by accessing our website at http://www.genoahealthcare.com or contacting Genoa at 1-888-GENOARX (1-888-436-6279).

_____ *(INITIAL)* I acknowledge receipt of the Notice of Privacy Practices of Genoa Healthcare, LLC.

Section 3. Brief Medical History

Diagnosis/Medical Conditions, please describe:_____

Medication Allergies: Y / N If yes, please describe:_____

Current Medications:_____

Current Pharmacy: _____

Section 4. Prescription Packaging and Delivery Method

Packaging Preference: *Vial – NON-Child Resistant* Y / N **|** *30-Day Card*: Y / N **|** *Genoa Care Packaging:* Y / N **|** *Other:*_____

____ *(INITIAL)* Medication is required to be dispensed with child resistant safety caps to prevent children from accidental ingestion. You may elect non-child resistant packaging. By selecting "Y" for any of the prescription packaging and initialing, you are requesting and acknowledge that your prescriptions will be dispensed in non-child resistant packaging, until such time that you revoke authorization

_____ (INITIAL) *Preferred delivery method (check one):* ☐ Pick up at pharmacy ☐ Mailed ☐ Delivery Driver

Section 5. Consent to Communication

By providing my telephone number to Genoa Healthcare on this Consumer Enrollment Form, I agree to receive automated calls, prerecorded messages, and/or text messages related to my health care from Genoa Healthcare and its affiliates. I may revoke or withdraw this consent at any time. Such withdrawal of consent must be made in writing. By providing my e-mail address on this form, I agree to receive e-mail messages from Genoa Healthcare and its affiliates. To stop receiving e-mails at any time, I may click "unsubscribe" at the bottom of the e-mail. Genoa Healthcare may send my PHI to me, by text message or email, in an unencrypted manner. I acknowledge and accept that communications may be sent unencrypted and there is some risk of disclosure or interception of the contents of these communications.

*Certain restrictions apply on certain medications, please consult with the Pharmacist to see if you qualify.

**Genoa Healthcare will not share any information obtained and will not use it for any other purpose but for the Refill Reminder Program.

I understand and acknowledge that I am personally responsible for the charges at this site and that Genoa Healthcare will bill my insurance as a courtesy. In the event of non-payment, I understand that I will be responsible for any outstanding balance.

Consumer Name (printed): _____
Signature:_____ **Date:**_____

If completing on behalf of a consumer
Authorized Representative Name (printed): _____
Signature:_____ **Date:**_____
Relationship:_____

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Before and After Admission

1. We ask that all tobacco products and nicotine vapes be in the original sealed packaging with clear labels. We do not permit the use of marijuana products in our facility.
2. Belongings brought to our facility should be kept to what is necessary during your stay. Items we recommend bringing are:
    a. Clothing items
    b. Personal hygiene supplies such as shampoo, conditioner, razor, toothbrush, toothpaste, lotions, etc.
    c. Chargers for electronic devices.
3. We do not allow medicinal marijuana to be used during your stay.
4. Personal bedding, pillows, and stuffed animals are prohibited and clothing will be laundered at intake.
5. Upon admission, we ask that residents go through belongings with staff for safety reasons. For safety purposes, we may ask to review items brought back into the facility when you are returning to the building.

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. 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.
    a. Dinner passes may be requested but must be related to treatment plan goals, or there must be extraordinary circumstances.
    b. All passes will be reviewed as a team on a weekly basis. All passes must be submitted by Thursday afternoon at 1:45pm to be considered for the upcoming week.
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 to ensure that we have adequate space to accommodate on-site visitation.
    b. 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.

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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.