1 FOR NEW DAY CLUBHOUSE REFERRAL 1

CHECKLIST

_____ pages 1-8 completed and signed
_____ last doctor/nurse assessment
_____ last 2-3 progress notes
_____ most recent plan of care

SEND COMPLETED PAPERWORK TO
SECURE FAX: 8645827111
SECURE EMAIL:
ndc@newdayclubhouse.com

PLEASE FILL OUT ALL FORMS COMPLETELY AND HAVE THE DOCTOR/ THERAPIST/ LPHA SIGN IN ALL 4 PLACES

INSTRUCTIONS

Page 1	Instruction /Checklist	
Page 2	REFERRAL FORM	
Page 3	REFERRAL FORM	DOCTOR / THERAPIST/ LPHA SIGN
Page 4	MEDICAL NECESSITY STATEMENT	Please include diagnosis codes Please provide rationale for the need for rehabilitative behavioral heath services. (why does this person need to come to New Day DOCTOR / THERAPIST/ LPHA SIGN
Page 5	RBHS referral form page 1	Please provide rationale for the need for rehabilitative behavioral heath services. (why does this person need to come to New Day DOCTOR / THERAPIST/ LPHA SIGN
Page 8	RBHS referral form page 4	DOCTOR / THERAPIST/ LPHA SIGN
Page 9	Authorization to disclose SCDMH PHI	Patient signs
Page 10	Admission Criteria to New Day	
Page 11-12	New Day Brochure	

1 1

NEW DAY CLUBHOUSE

325 S. Church St.
Spartanburg, South Carolina 29306
Telephone: (864) 582-5431 Fax: (864) 582-7111 E-Mail: ndc@newdayclubhouse.com

Referral Form

Name:_____ Client ID # *(if applicable)*:_____

Address:_____ Phone #:_____

_____ Social Security#:_____

_____ Date of Birth:_____

Insurance Information: Medicaid #_____ Medicare #:_____

Other Insurance:_____
Company Name Address

Living Situation (circle one): Alone With Parent(s) Spouse Children Friends
Other:_____

Principal Diagnosis:_____

Secondary Diagnosis:_____

Other Medical Diagnoses:_____

Medications *(Name, Dose, Frequency)*:_____

_____

_____

Psychiatric Hospitalizations *(Hospitals, Dates, Length of Stay):*_____

_____

_____

Rate living skill competencies in the following areas:

(1) Does not need assistance; (2) Needs some assistance; (3) Needs ongoing assistance

_____Community living competencies (self-care, cooking, money management, personal grooming, maintenance of living environment)
_____Social and interpersonal competencies (conversational competency, developing and/or maintaining a positive self-image, ability to maintain positive relationships)
_____Personal adjustment competencies (ability to handle life experiences/crises, stress management, leisure time management, coping with symptoms of mental illness)
_____Cognitive and adult role competencies (able to develop/maintain cognitive abilities, adult role functioning such as increased attention, improved concentration, enhancing ability to learn, establish to ability to develop empathy
_____Prevocational activities (positive work habits, meaningful activities and/or employment, time management, prioritizing tasks, taking direction, following policies/rules and procedures, problem solving/conflict resolution, building appropriate relationships with co-workers and persons of authority, on-task behavior and task completion skills)

4 4

Other Psychosocial Treatment Needs:_____

_____

History of medication compliance: ( ) Excellent ( ) Good ( ) Fair ( ) Poor
How does client behave when off medications?_____

Currently uses alcohol/drugs? ( ) yes ( ) no If yes, explain:_____

_____

Compliance with treatment plan: ( ) Excellent ( ) Good ( ) Fair ( ) Poor
Comments:_____

Behavioral Concerns/Comments:_____

_____

_____

Please list all services provided to this referral during the past twelve months:_____

_____

_____

Interpretive Summary (*last 90 days*):_____

_____

_____

_____

_____

_____

Other Comments:_____

_____

_____

_____

Primary Psychiatrist:_____ _____
Signature Printed

Therapist:_____ _____
Signature Printed

Agency:_____ Phone #:_____

Address:_____

_____

**Please send the following (if applicable) along with the referral form:

_____ last hospital discharge

_____ Progress notes (2-3 notes)

_____ Doctor/Nurse assessment

_____ RBHS form (signed in the last 14 days)

4 4

South Carolina Department of Health & Human Services

MEDICAL NECESSITY STATEMENT FOR REHABILITATIVE SERVICES

Beneficiary's Name: _____ Social Security Number: _____

Date of Birth: _____ Medicaid Number: _____

Diagnosis code(s): _____

[Diagnosis codes must be based on the current edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* or the International *Classification of Diseases (ICD).*]

I recommend that the above-named Medicaid beneficiary receive Rehabilitative Services(s) for the maximum reduction of emotional, behavioral, and functional developmental delays and restoration of the beneficiary to his or her best possible functioning level. This beneficiary meets the Medical Necessity criteria for Rehabilitative Services as evidenced by a Psychiatric diagnosis from the current edition of the DSM or the ICD.

Indicate the specific Rehabilitative Service(s) being recommended on each line below.

Rehabilitative Service(s): _____, _____, _____

Rehabilitative Service(s): _____, _____, _____

Identify the Beneficiary's problem areas for Rehabilitative Services listed above. The recommendation must be based on recent clinical information, staffing recommendations, review(s) of treatment history and/ or evaluation(s) made within federal and state standards

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

(Signature of Physician) (Professional Title)

_____ _____

(Please print name signed above) (Phone Number)

Signature Date: _____ (Services must be initiated within 45 calendar days.)

Must be handwritten

Note: The MNS and supporting documentation must be submitted to the QIO using one of the following methods: KePRO Fax #:855-300-0082 or via the KePRO website: http://scdhhs.Kepro.com

Revised: 06/2012

6 6

SOUTH CAROLINA Healthy Connections MEDICAID

Nikki Haley GOVERNOR
Christian L. Soura DIRECTOR
P.O. Box 8206 > Columbia, SC 29202
www.scdhhs.gov

Rehabilitative Behavioral Health Services (RBHS) Referral Form

This form shall be completed only by state agencies and submitted to private RBHS providers in accordance with HIPAA regulations as it contains Protected Health Information (PHI) of Medicaid beneficiaries.

Referring State Agency	☐ Department of Social Services Region: ☐ Department of Mental Health CMHC: ☐ Continuum of Care Region: ☐ Department of Alcohol and Other Drug Abuse Services Commission:	☐ Department of Disabilities and Special Needs Region: ☐ Department of Juvenile Justice Region: ☐ Department of Education District:

Provider (Referred to)	New Day Inc. of Spartanburg			**NPI**	1851613186
Address	325 South Church Street				
City	Spartanburg	**State**	SC	**Zip**	29306
Phone Number	864-582-5431	**Fax Number**	864-582-7111		

Beneficiary Name			
Legally Responsible Person(s)	self		
Address			
City		**State**	**Zip**
Date of Birth		**Gender**	☐ Female ☐ Male
Social Security Number (last 4 digits)		**Medicaid Number**	

Medical Necessity	
Diagnosis – Code / Description	/
Diagnosis – Code / Description	/
Diagnosis – Code / Description	/
Clinical Rationale for Rehabilitative Behavioral Health Services Recommendations	

I recommend that the above-named Medicaid beneficiary receive Rehabilitative Behavioral Health Services. This beneficiary meets the Medical Necessity criteria for services as evidenced by a mental health and/or substance use disorder from the current edition of the DSM or the ICD.

Name of LPHA: ψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψ

Credentials: ψψψψψψψψψψψψψψψψψψψψ

Signature of LPHA: ψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψ

5l·te: ψψψψψψψψψψψψψψψψ

Recommendations for Rehabilitative Behavioral Health Services							
	Service Description	**Procedure Code**	**Unit**	**Total Units Authorized**	**Start Date**	**End Date**	**Specific Frequency (# of units per day, # of days per week)**
SCREENING AND ASSESSMENT SERVICES							
☐	Behavioral Health Screening	H0002	15 minutes				
☐	Psychiatric Diagnostic Assessment without Medical Services - Initial	90791	Encounter				
☐	Psychiatric Diagnostic Assessment with Medical Services – Initial	90792	Encounter				
☐	Mental Health Comprehensive Diagnostic Assessment – Follow–up	H0031	Encounter				
☐	Psychological Testing / Evaluation	96101	60 minutes				
☐	Comprehensive Evaluation – Initial	H2000	Encounter (average of 3 hours)				
☐	Comprehensive Evaluation – Follow up	H0031	Encounter				
SERVICE PLAN DEVELOPMENT							
☐	Mental Health Service Plan Development (Non-physician)	H0032	15 minutes				
☐	Service Plan Development (Team Conference w/ Client/Family)	99366	Encounter (minimum 30 minutes)				
☐	Service Plan Development (Team Conference w/o Client/Family)	99367	Encounter (minimum 30 minutes)				
CORE TREATMENT – PSYCHOTHERAPY AND COUNSELING SERVICES							
☐	Individual Psychotherapy	90832	30 minutes				
☐	Individual Psychotherapy	90834	45 minutes				

Recommendations for Rehabilitative Behavioral Health Services							
	Service Description	**Procedure Code**	**Unit**	**Total Units Authorized**	**Start Date**	**End Date**	**Specific Frequency (# of units per day, # of days per week)**
☐	Individual Psychotherapy	90837	60+ minutes				
☐	Group Psychotherapy	90853	60+ minutes				
☐	Family Psychotherapy w/o Client	90846	60+ minutes				
☐	Family Psychotherapy w/ Client	90847	60+ minutes				
☐	Multiple Family Group Psychotherapy	90849	60+ minutes				
☐	Crisis Management	H2011	15 minutes				
☐	Medication Management	H0034	15 minutes				
COMMUNITY SUPPORT SERVICES							
☒	Psychosocial Rehabilitation Service (PRS)	H2017	15 minutes				
☐	Behavior Modification (B-Mod)	H2014	15 minutes				
☐	Family Support (FS)	S9482	15 minutes				
☐	Therapeutic Child Care	H2037	15 minutes				
☒	Community Integration Services	H2030	15 minutes				

Note: Prior authorized periods of time for Community Support Services are as follows:

- Beneficiaries ages 0 to 21: Up to 90 days
- Beneficiaries age 22 and older: Up to 180 days

State Agency Representative Authorization (optional, per internal state agency processes)

Name: ψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψ

Phone: ψψψψψψψψψψψψψψψψψψψψψψψψ

Title: ψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψ

Signature: ψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψ Date: ψψψψψψψψψψψψψψψψ

NEW DAY CLUBHOUSE

PSYCHOSOCIAL REHABILITATION PROGRAM

AUTHORIZATION TO FURNISH INFORMATION IN THE CASE OF:

_____
(Name)

_____
(Date of Birth)

_____
(Date of Admission)

I authorize New Day Clubhouse to obtain and/or release medical records and communications relative to my diagnosis and treatment for medical, psychiatric, and/or substance abuse conditions to: (Name and Address)

_____

_____

for the purpose of:

Re-evaluation, planning and treatment

OR _____

This authorizes release of the following: Psychiatric and/or medical records. I understand that refusal to grant consent will in no way jeopardize the right to obtain present or future service except where disclosure of such communication and records is necessary for treatment. Withdrawal of consent shall in no way affect communications or records disclosed before notice of such withdrawal. I understand the benefits and disadvantages of my decision concerning release of information specified above. I also acknowledge that I may revoke this authorization at any time by contacting a staff at New Day (either in writing or documented phone call).

SIGNED_____
(Member, next-of-kin, guardian or executor as appropriate)

WITNESS:_____

DATE_____

Expiration Date*:_____ ***This authorization expires 1 year from date signed unless otherwise indicated.***

_____

I have been informed of the New Day Clubhouse privacy practices. (On Back)

SIGNED_____
(Member, next-of-kin, guardian or executor as appropriate)

01/2009

TITLE: Member Admissions Criteria
POLICY: F1.0
APPROVED: 4-27-88
REVISED/REVIEWED: 10-02-22

PURPOSE: To identify member admissions criteria for New Day Clubhouse.

The following criteria should be used in assessing whether or not individuals will be admitted into membership at New Day Clubhouse.

Acceptance Criteria

A. Person must be at least eighteen (18) years or older with an established history of severe and persistent mental illness (SPMI), which includes, but is not limited to, one of the following diagnoses: Schizophrenia, Bipolar Disorder, Major Depression, Psychotic Disorder NOS, or schizoaffective disorder.

B. Person must need a structured day program and community-based services to prevent hospitalization or to maximize functioning in the community.

C. Person must be followed in treatment by a Licensed Practitioner of the Healing Arts (LPHA) throughout clubhouse membership.

D. Final acceptance and clubhouse membership shall be made by the Executive Director of New Day, Inc. of Spartanburg.

Non-Acceptance Criteria/Referral to Another Program

A. Persons suffering from severe disorientation and confusion.
B. Persons who have no self-help skills and cannot complete ADL's (activities of daily living).
C. Persons who cannot follow simple instructions.
D. Persons who are a danger to themselves or others.
E. Persons who are constantly disturbing to others or display anti-social behavior.
F. Persons who have a history of either:
   - ♦ Recent history of violent or physical and/or verbally abusive behavior.
   - ♦ Recent history of inappropriate sexual behavior.

Persons with a *primary diagnosis* of a mental disability other than severe and long-term mental illness (i.e., autism spectrum), who would be better served by rehabilitation programs specifically designed to meet their needs including:

- ♦ Alcohol and/or drug abuse
- ♦ Intellectual/Developmental disability or autism spectrum
- ♦ Head injury/traumatic brain injury

Statement of Non-Discrimination

New Day does not discriminate on the basis of race, color, spiritual beliefs, gender, national origin, age, handicap, sexual orientation, marital or parental status in admitting individuals with mentally illness for services.

In February 2023 the Policy and Procedure Manual was reorganized some policies may have changed names and or numbers. As a reference this policy's old name and number are:
OLD POLICY NAME: Member Admissions Criteria
OLD POLICY NUMBER: 35-02

Employment Programs

Transitional Employment

The Placement Manager, a New Day staff person, learns the position and then trains the member. Members work part-time and up to five days per week. The member receives the prevailing wage for the position. In a member's absence there is guaranteed coverage by the Placement Manager at no cost to the company.

Supportive Employment

New Day staff provides supportive services throughout the entire employment process. New Day helps to establish and maintain an open-relationship between the employee and employer through personal visits and/or phone calls. The staff also provides the member with many other services such as job referrals and resume development.

Independent Employment

Members utilize the clubhouse for continual support. The staff/peer provide networking with the business community and to maximum their job effectiveness and performance.

How do you become a member of New Day Clubhouse? Referrals are made by your Mental Health Provider to New Day. If you are interested in becoming a part of the clubhouse, please call us and ask for a tour of the facility. We will be glad to provide you with a referral form to take to your Mental Health Professional.

Membership/Attendance Fees: Payments to attend the clubhouse program are based on a sliding scale. We accept private pay, insurance and Medicaid. Please call for more information.

Please visit our web page at:

New Day is a 501(C)3 non-profit organization and contributions to New Day are tax deductible. New Day is affiliated with the United Way of the Piedmont and the Spartanburg Area Mental Health Center. New Day is a member of the International Center for Clubhouse Development and is accredited by CARF - The Rehabilitation Accreditation Commission for the Community Based Rehabilitation Programs for its Community Integration—Adults, Psychosocial Rehabilitation Program.

325 S. Church St
Spartanburg, SC 29304

Phone: 864-582-5432
Fax: 864-582-7111

Email us at ndc@newdayclubhouse.com

New Day, Inc. of Spartanburg

(Also known as)

New Day Clubhouse

NEW DAY CLUBHOUSE

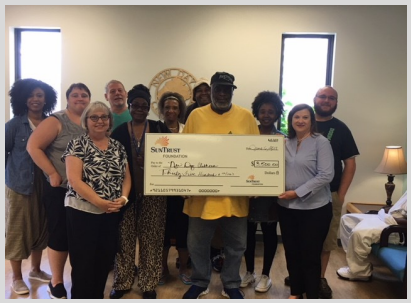
A PSYCHIATRIC REHABILITATION FACILITY

A GREAT PLACE TO FEEL NEEDED, WANTED, AND EXPECTED

New Day, Inc. of Spartanburg, also known as New Day Clubhouse, was founded in 1987 as a private, nonprofit organization through the efforts of the Mental Health Association of the Piedmont. New Day is a psychiatric rehabilitation center serving adults, 21 years and older, with a diagnosis of mental illness. Adults aged 18-21 will be evaluated on an individual basis to ensure an appropriate fit for services.

The mission of **New Day** is to assist people with mental illness to develop their abilities to live as independently as possible within the community.

The individuals we serve are called members, not clients or patients. The clubhouse provides support, understanding, and opportunities for personal growth. All services focus on the individual's strengths, talents, and abilities, and are designed to promote successful social and vocational adjustment to community life and independent living.

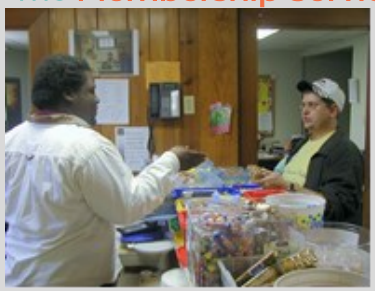


Program and Services

The clubhouse is open daily between 8:00 a.m. to 4:00 p.m. Off-site activities are offered in addition to the multitude of fun and learning opportunities that are offered daily on-site. The members learn the value of commitment, responsibility, and teamwork through voluntary involvement in the work-ordered day. Members volunteer to participate in one of the three work units while at New Day.

Members on the **Administrative Unit** complete office and clerical duties such as word processing, data entry, filing and billing. The members also write, edit, and produce a periodic newsletter.

The **Membership Services Unit** keeps the facility clean, the grounds neat, and the vans running smoothly. The unit also operates a snack bar during the work-ordered day. Members working with the **Food Service Unit** plan meals, shop at local stores, prepare a weekly menu, as well as cook, sell and serve breakfast and lunch daily. They operate like a small restaurant. And learn to use the skills necessary to be successful in the food industry



Additional Services

New Day members have the opportunity to enjoy a wide variety of social and recreational activities. Events are held in the afternoon, evenings and weekends. Bowling, shopping, bingo, and trips to area attractions are a few of the popular activities. The snack bar area is also used for members to socialize informally during the day while enjoying refreshments.

Housing

New Day is committed to providing safe, decent, and affordable housing for qualifying members. New Day operates two apartment complexes, Newport Apartments and Wilkinson Place. Both 20-unit complexes are furnished and equipped with some kitchen, bedroom, and bathroom supplies.