FOR NEW DAY CLUBHOUSE REFERRAL

CHECKLIST

- ________ pages 1-9 completed and signed
- ________ last doctor/nurse assessment
- ________ last 2 or 3 progress notes
- ________ most recent plan of care

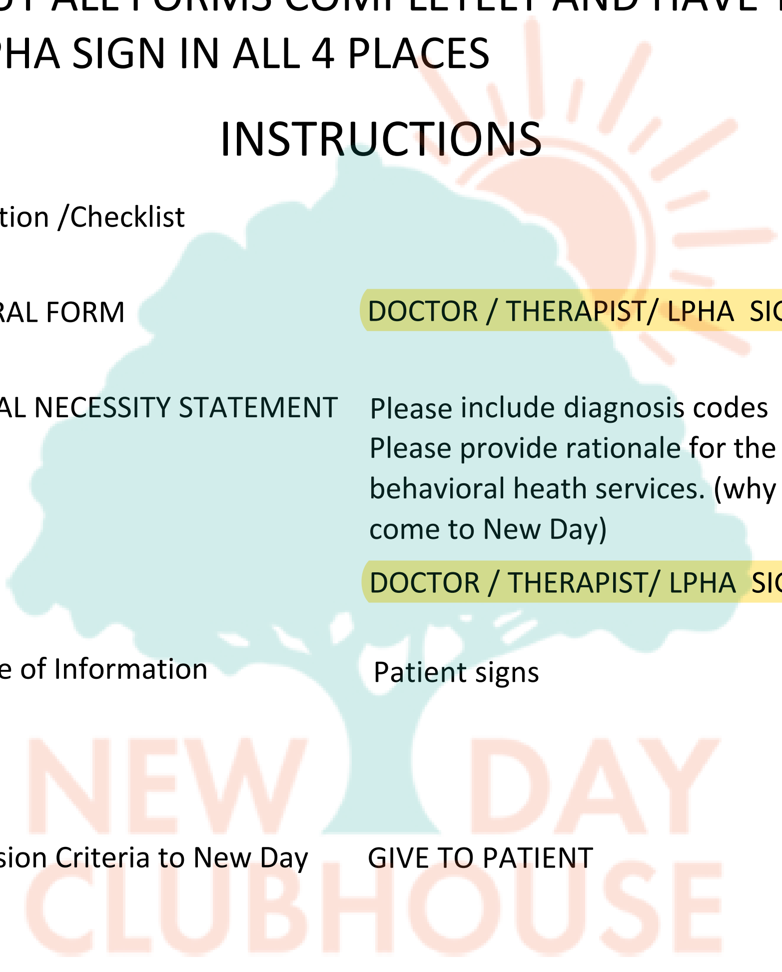
SEND COMPLETED PAPERWORK TO

SECURE FAX: 8645827111

SECURE EMAIL: ndc@newdayclubhouse.com

If you have questions about completing this packet, please contact Andrew Turner 864-582-5431

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



INSTRUCTIONS

Page 1	Instruction /Checklist	
Page 2-3	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	Release of Information	Patient signs
Page 6	Admission Criteria to New Day	GIVE TO PATIENT

NEW DAY CLUBHOUSE
325 S. Church St, P. O. Box 1869
Spartanburg, South Carolina 29304

Telephone: (864) 582-5431 Fax: (864) 582-7111 **E-Mail: ndc@ndclubhouse.com**
ATurner@NewDayClubhouse.com

Referral Form **Date:_______________**

Name:____ Client ID # *(if applicable)*:____________________________

Address:______________________________________ Phone #:____

____ Social Security#:________________________________

____

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:____

Referring Agency Admission Date *(Date individual came to your agency)*:______________________________

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

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

Rate living skills in the following areas:

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

_______Housekeeping _______Transportation _______Money Management

_______Food Preparation and Storage _______Communication (e.g. use phone, make Appointments) _______Ability to Arrange Health Care

_______Grocery Shopping _______Leisure time planning _______Interpersonal Skills

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*):____

____

____

____

Have you reviewed the New Day Admissions Criteria for this referral? ( ) yes ( ) no

Other Comments:____

____

____

____

Primary Psychiatrist:_________________________________ _________________________________

Signature Printed

Therapist:_________________________________ _________________________________

Signature Printed

*Agency:_________________________________ Phone #:_________________________

Address:____

____

Contact Email ______________________________________

***PLEASE NOTE THAT A COMPLETED DIAGNOSTIC ASSESSMENT (WITHIN 45 DAYS OF NDC SERVICE DATE) MUST BE SENT WITH THE REFERAL FORM.**

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

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