Two New Locations. Many Roads To Recovery.

MHA is now accepting referrals for our two new dual diagnosis (mental health and substance use) Residential Rehabilitation Services programs. Our new Springfield residence is welcoming young men 18-26 and our Holyoke location is welcoming LGBTQ+ adults 18 years and older. To make a referral or to learn more, please call **844-MHA-WELL** (Press Option 1) or visit **www.mhainc.org/GRIT.**

MHA

Respect • Integrity • Compassion

MHAINC.ORG | 844-MHA-WELL

Referral Packet- GRIT

Mental Health Association, Inc.
Residential Rehabilitation Services (RRS), Co-Occurring Enhanced Program

To make a referral to the GRIT program, please utilize the referral and screening packet attached. For initial referral please contact the Central Intake Coordinator at: 413-233-5312. Please fax completed referral packet to 413-737-7949 or email to kroman@mhainc.org.

Important information to include:

- Date of transition or discharge from referring program;
- Basic demographic and insurance information (copy of card if available);
- A list of current medication(s) and prescriber(s)
- Screening information to identify that the individual meets the admission criteria for this level of care (please provide a comprehensive answer to each question, where possible)
- **This packet also includes a list of exclusionary criteria. Please review prior to making referral**

MHA
Respect • Integrity • Compassion

GRIT
RECOVERY WITH PURPOSE

Referral For: _____ ***Wilbraham***, Springfield (Men 18+) _____ ***Yale***, Holyoke (18+, LGBTQ+) _____ ***Ridgewood,*** Springfield (Young Men 18-26) _____ ***Unsure***	
Referral Source:	Contact Person:
Contact Telephone:	Contact Fax:
Anticipated Date of Release: / /	Requested Date of Admission: / /
Name:	Other names:
Date of Birth: / /	Social Security Number: - -
Housing Status: ❑ Secure ❑ Planned ❑ Unknown	
Address*(Street)*:	*(City, State, Zip Code)*
Telephone Number:	
Emergency Contact Name & Relationship:	
Emergency Contact Telephone Number:	
Reason for Referral:	
Primary Care Provider:	Practice:
Telephone:	Date of Last Visit: / /
Insurance Carrier:	Insurance Number:
Employer:	
Subscriber Name:	Relationship to Subscriber:
Subscriber Date of Birth:	Subscriber Address:
Secondary Insurance Carrier:	Secondary Insurance Number:
Employer:	
Subscriber Name:	Relationship to Subscriber:
Subscriber Date of Birth:	Subscriber Address:

1. Describe individual's pattern of substance use at time of admission, including alcohol and/or other substances used, amount used and route of administration.

   _____
   _____
   _____
   _____

2. Describe individual's mental health diagnosis, disruption in functioning and concerns.

   _____
   _____
   _____
   _____

3. Describe individual's current and most recent treatment for substance use and mental health, including any recent emergency room contacts, hospitalizations or Section 35.

   _____
   _____
   _____
   _____

4. List medications that are currently prescribed and current prescriber(s). Include individual's experience self-administering medication and assessment of their current ability to self-administer.

   _____
   _____
   _____
   _____

5. Please list any known allergies.

   _____
   _____
   _____

6. Is individual currently prescribed any forms of MAT? If yes, please provide detail.

_____

_____

7. Is individual voluntary for admission to treatment for both substance use and mental health?

_____

_____

8. Does individual have any current service providers or community resources? If yes, please provide information.

_____

_____

_____

9. Any identified areas of focus or treatment preferences?

_____

_____

_____

10. Does individual have any special needs or disabilities requiring accommodation?

____Yes ____No

If yes, please specify_____

11. Current legal involvement- open cases, probation, parole?

_____

_____

_____

12. Current or history of gang affiliation? ____Yes ____No

If yes, Describe_____

13. Convicted of a sex offense? ____Yes ____No

    If yes, Level?_____

14. Are there any *immediate needs* the program should be aware of (i.e. access to clothing, medication, required medical supplies, id's, insurance cards, etc)?

    _____

    _____

    _____

    _____

Exclusionary Criteria

Individuals may be considered ineligible for admission to GRIT Co Occurring Enhanced RRS programs for any of the following identified reasons:

1. They do not have a mental health diagnosis or need requiring the treatment for co-occurring disorders;

2. The substance use disorder and mental health diagnosis can be effectively treated in a different level of care, not requiring intensive treatment;

3. The individual does not require overnight clinical supervision, does not require substantial individualized staff attention and could be effectively treated in a less intensive level of care;

4. The individual is experiencing symptoms of severe withdrawal that require the resources of a hospital, emergency department and/or medically monitored withdrawal management facility, such as an acute treatment services program; or,

5. The individual cannot be appropriately treated and/or is not safe in a community-based setting based on acute psychiatric symptoms.

6. Individuals with level 3 sex offenses will not be eligible for admission to GRIT programs.

995 Worthington Street, Springfield, MA 01109 Telephone 413-734-5376 FAX 413-7949

AUTHORIZATION TO REQUEST AND RELEASE PROTECTED HEALTH INFORMATION*

Name:_____ Address:_____

Date of Birth:_____

I authorize the following person(s) and/or organizations to release and/or receive my protected health information:

_____ _____
Hospital/Clinic/Treating Physician Date(s) of treatment

I authorize the following person(s) at the Mental Health Association, Inc. to receive and/or release my protected health information:

_____
Name / Title / Program

I specifically authorize the release of personal health information relating to my substance abuse treatment, records and current status. ( ) *Yes ( )* No Initial _____

I specifically authorize the release of personal health information relating to AIDS or HIV treatment, records or current status. ( ) Yes ( ) No Initial _ _____

The specific information to be disclosed is:

( ) Discharge Summaries
( ) Admission Notes / Mental Status
( ) Operative Notes
( ) Psychology Testing Reports
( ) Out Patient Summaries
( ) Laboratory Reports
( ) Radiology Reports
( ) MRI Reports, CAT Scan Reports
( ) EEG's, EKG's
( ) Other, Specify: _____

( ) The information may be released via telephone.

The information is needed for the following purpose: ( ) Treatment ( ) Other: _____

I understand that this consent is subject to revocation at any time unless action based on this release has already been taken. I understand that further disclosure of the information to be released may not be made without my written consent or as otherwise restricted by Federal Regulations (42 Code of Federal Regulations, Part 2) and HIPAA.

This consent will expire in one (1) year.

_____ _____
Signature of Consumer Date

_____ _____
Signature of Parent/Guardian/Legal Representative Date

_____ _____
Signature of Witness, Title Date

* Protected health information ("PHI") is health information that is created or received by a health care provider, health plan, or health care clearinghouse which relates to: I) the past, present, or future physical or mental health of an individual; 2) the provision of health care to an individual; or 3) the past, present, or future payment for the provision of health care to an individual. To be protected, the information must be such that it identifies the individual or provides a reasonable basis to believe that the information can identify the individual