



Thank you for choosing Red Mountain, we appreciate your business. Attached is our Referral Cover Sheet. Please complete the top portion of the Referral Form and fax it along with the required documents listed below. Having a complete referral packet will help us to begin services as soon as possible. This cover sheet also serves as the fax cover sheet for your convenience.

FAX TRANSMITTAL FORM

To: Red Mountain BHS
Intake Coordination

From: _____

Date Sent: _____

Phone: 480-641-9552

Number of Pages: _____

Fax: 480-981-0893

Please attach the following required documents:

- 1. Referral Face Sheet
- 2. Behavioral Supplement
- 3. Release of Information
- 4. Participation Consent
- 5. Self-Administration of Medication Policy and Procedure Consent Form
 - The signature should be the primary caregiver with physical custody of the child.
 - Initial for over the counter drugs at the bottom.
 - **All medication must** come in the original, correctly labeled pharmacy container.
- 6. Treatment/Service Plan with specific services & RMBHS (signed by Case Manager or Therapist)
- 7. Current Annual Behavior Assessment (signed by Case Manager or Therapist)

<p><u>*Additional Requirements for Cenpatico Clients:</u></p> <ul style="list-style-type: none"><input type="checkbox"/> Strengths, Needs, & Cultural Discover Assessment<input type="checkbox"/> Crisis/CFI/Safety Plan
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The following additional documents are for **providing information to the guardian** about our program. Please note: **it is not necessary** send these back to RMBHS:

- Welcome Letter
- Scheduling Policies
- Program Rules

This fax is confidential and intended solely for the use of the individual or entity to whom it is addressed. If you have received this fax in error please notify the sender and destroy this message.



BEHAVIOR SUPPLEMENT

Date: _____

Name: _____

Please Note: Our purpose for requesting the following information is to provide the most positive experience possible for each child placed in our care.

Reasons for referral: Check all that apply.

- | | | |
|---|--|---|
| <input type="checkbox"/> . Depression | <input type="checkbox"/> . Aggression / Violence | <input type="checkbox"/> . Sexual perpetration |
| <input type="checkbox"/> . Conduct disorder / Other | <input type="checkbox"/> . ADD | <input type="checkbox"/> . Suicidal |
| <input type="checkbox"/> . History of sexual abuse | <input type="checkbox"/> . ADHD | <input type="checkbox"/> . History of self mutilation |
| <input type="checkbox"/> . Encopresis / Enuresis | <input type="checkbox"/> . ODD | <input type="checkbox"/> . Substance abuse |
| <input type="checkbox"/> . Gang involvement | <input type="checkbox"/> . PTSD | <input type="checkbox"/> . Eating disorders |

Additional behaviors of concern that may impact the respite environment or behavioral health treatment: _____

Physical limitations: _____

Allergies: _____

Please fax all referral documentation to Red Mountain Behavioral Health Services

*Intensive behaviors may require a psychosocial history, last psychiatric evaluation upon RMBHS request.

Phone: 480.641.9552 Fax: 480.981.0893
E-mail: info@rmbhs.com
www.rmbhs.com



CONSENT AND AUTHORIZATION FOR RELEASE CONFIDENTIAL INFORMATION

Client Name: _____

I, (client or legal guardian name) _____ give my consent and authorize Red Mountain Behavioral Health Services LLC, to release to (name of agency/person & relationship):

___ Gila River Health Care ___ Pascua Yaqui Tribe ___ Cenpatico Intake Agency: _____
 ___ Salt River Social Services ___ WM Apache Tribe ___ Other _____

protected health information for the sole purpose of: _____ coordination of care _____

Check this box if each of the above parties may disclose your information to, and receive your information from, the other party.

I understand that information will be disclosed only for the purpose(s) noted above, and that the release of information will be limited to the following information. Mark through any item you did not wish to be shared (Example: ~~Progress Notes~~).

- Psychiatric/Psychological/Social Assessment
- Treatment Plan / Review
- Progress Notes
- Oral Communication
- Test / Lab Results
- Biopsychosocial Assessment
- Case Staffing
- Discharge Plan
- Medications
- Other: _____

Dates of records: From: _____ To: _____ or, if no dates are specified, all dates will be released.

I understand that my medical record to be released may contain medical information pertaining to behavioral or mental health services, drug and /or alcohol diagnosis and treatment. I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV).

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR, part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action had been taken in reliance on it, and that in any event, this consent expires automatically three months after my discharge from Red Mountain Behavioral Health Services.

I have been offered a copy of this form and I have: Accepted Refused

Signature of Client/Guardian*:		Date:
Other required signature if applicable:	Relation to Client:	Date:
Signature of Witness:	Title/Credential:	Date:

*** If the client is between 12-18 years of age, both his/her signature is preferred along with the required signature of the parent or legal guardian.**

NOTICE TO RECIPIENT OF INFORMATION: Federal regulations prohibit you from making any further disclosure without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. 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 drug or alcohol abuse client.



Print Client's Name _____

I have legal custody of the above mentioned and I hereby authorize him/her to participate in the care of *RMBHS, LLC*. I understand that while in care my child will take part in off site outings. I authorize my child to participate in these outings and to be transported by *RMBHS, LLC., RMBHS employees, agents or contractors.*

Directions to client's home: _____

While every effort will be made to maintain a safe environment, I understand that a mishap may take place while in care. Should an emergency arise, I consent to any licensed medical personnel to x-ray, examine, use anesthetic, or perform any medical or surgical procedure necessary to maintain the well being of the child. I agree to be responsible for any charges not covered by applicable insurance. I understand that should my child become a danger to self or others that an emergency safety response (CPI child control position) will be utilized. I also authorize my signature to be considered consent for medical billing, specifically submitting Medicaid services (claims) that have been provided for my child. I will not hold *RMBHS, LLC, RMBHS employees, agents or contractors thereof* liable for compensation.

Guardian Signature _____ Date _____

Medical/Hospital Insurance Carrier _____

Policy/Group Number _____

Allergies to Medications _____

Medications Needed: **PLEASE REFERENCE THE CURRENT SELF-ADMINISTRATION OF MEDICATIONS CONSENT**

Emergency Contacts: A child can only be signed into or out of care by a legal guardian or a person over 18 years of age authorized by the legal guardian in writing. Please list the **names and phone numbers** of anyone allowed to sign your child in or out of care. RMBHS will not release your child to anyone not listed below.

- | | |
|---------|---------|
| 1 _____ | 5 _____ |
| 2 _____ | 6 _____ |
| 3 _____ | 7 _____ |
| 4 _____ | 8 _____ |

RMBHS Self-Administration of Medication Policy & Procedure



1. While attending services with Red Mountain Behavioral Health Services, clients may take medications as prescribed by a physician.
 - a. Over the counter medications may be taken with written guardian consent.
 - b. Respite staff will always monitor self-administration of both over the counter and prescribed medications.
 - c. All clients must have a "Consent to Self Administer Medications" signed by their guardian.
 - d. Medications for self-administration will be kept in a locked box except during times of self administration.
2. **Medications must be in a current and accurately labeled pharmacy prescription container.**
3. Self-Administration of Medication
 - a. Staff will prompt clients to take medications at their prescribed time.
 - b. In the event that medications are prescribed in an "as needed" (PRN) manner rather than specified times, a customary time schedule for self administration will be established in consultation with the client's guardian(s) during the sign-in process (i.e. a 3X daily medication to be given following each meal time). All variances will be documented on the medication log form.
 - c. Staff will directly supervise client's dispensing of his/her own medication
 - 1) Prior to the client taking the medication, staff will confirm that the client has prepared the proper dosage and time per consent form, referencing the prescription bottle and the medication consent sheet, as needed. Staff will ask the client to identify where his or her name is on the prescription bottle.
 - 2) If the client cannot appropriately self-administer the medication, the guardian and Respite Manager will be contacted for consultation.
4. Respite staff will log the monitoring of client's self-administration of medication. Any failure of a client to take their prescribed medication will be logged by attending respite staff. Guardian(s) and the referring provider will be immediately notified of any deviation from the prescribed regimen.

Consent for Self-Administration of Medication

I have read the above policy and understand the procedures for self-administration of medication for my child. I agree to abide by the self-administration of medication policy & procedure and consent to Red Mountain Behavioral Health Services agents, employees, or contractors to monitor the self-administration of medication for my child.

RMBHS will provide and monitor the self-administration of over-the-counter medications to clients with guardian consent.
Please indicate if the client may be given the following by circling either "YES" or "NO."

Acetaminophen (i.e. Tylenol or generic versions)	YES	NO
Ibuprofen (i.e. Advil or generic versions)	YES	NO
Throat Lozenges/Cough Drops (Various)	YES	NO
Lice Treatment (various shampoos, sprays)	YES	NO

Print Client Name: _____

Print Guardian Name: _____

Guardian Signature: _____ Date: _____

RMBHS Staff Signature: _____



Now that you've completed the required paper work to enroll into Red Mountain, the next step is to send your child to us. Your case manager will help you decide when to use this service and let the Red Mountain office staff know.

We realize that it is important for you to be able to get in touch with your child at all times. We encourage you to contact us at any time at one of the following phone numbers.

RMBHS Office: 480-641-9552
Toll-Free/After Hours: 1-800-318-1804

Locations:

- We have several locations in the East Valley area.
- We select a location best suited for your child based on:
 - Age
 - Gender
 - Interests and Abilities
 - Special requests made by case managers or parents
- All houses have a maximum of 5 children to 1 staff ratio.
- Most homes have 9 children with 2 staff, usually a husband and wife team.
- Exact location and phone number information to the respite home your child will be staying in is always available to each family upon specific parental request.

Thank you for allowing your child to participate. We value your feedback and look forward to working with your family!

Randy and Robin Kinsel

Founders of Red Mountain Behavioral Health Services
Providing respite services to the children of Arizona since 2002

**Red Mountain Behavioral Health Services, LLC,
1223 S Clearview Ave #110, Mesa, AZ 85209
Toll Free: 1-800-318-1804
Direct: 480-641-9552**



General Policies & Procedures

1. **Pre-schedule:** When appropriate, pre-scheduling respite services may assure that a place will be available for the child. However, crisis and other unplanned respite can be requested and will be reviewed based on availability and appropriateness.
2. **Scheduling:** The Red Mountain office staff handles all of RMBHS scheduling. Our contacts are: Toll-Free: 1-800-318-1804, Direct: (480) 641-9552. Each child begins with 720 hours of respite. By developing a respite plan that best suits the client's needs, hours can be used to most benefit the client. At all times, scheduling respite services should be done in coordination with the client's case manager and/or primary therapist.
3. **24-hour notice for scheduling:** While emergency situations do occur, we understand and will be flexible for both respite stays and cancellations. Please consider that RMBHS plans outings in advance and will often need an accurate head count in advance.
4. **Cancellation Policy:** Due to limited space, we request that once respite is scheduled, cancellations occur with 24-hour notice. When less than 24 hours notice is given, it may prohibit families that desperately need respite. While emergency situations do occur, we understand and will be flexible for both respite stays and cancellations.
5. **Medication Policy:** Medication must arrive in the original bottle with the child's name, and correct dosage written on the bottle by the Pharmacy. A written consent form, signed by the parent is required before we can monitor medications. While we are trained in CPR and First Aid, we are not medical staff. RMBHS monitors medication intake but cannot administer medications. Clients must be able and willing to take medications voluntarily.



Dress code

It is necessary for all participants in RMBHS's care to comply with clean and comfortable attire. While there are several options that are acceptable, we request the following standards to be followed:

Females

1. Shorts of modest and appropriate length may be worn.
2. No spaghetti straps, tube tops, or halter-tops. A bra must be worn at all times
3. Tops that are low cut or that reveal cleavage are unacceptable
4. A "cover up" top must be worn over all two-piece bathing suits. A one-piece suit is best
5. Extremes in modes of dress such as see-through clothing, exposed midriffs, or clothing normally considered as undergarments are not acceptable
6. All flesh between the shoulder area and 3 inches above the knee must be covered at all times
7. Apparel that advertises or depicts alcohol, drugs, nudity, tobacco products, satanic themes, gang membership, obscene language, obscene graphics, and/or phrases that are offensive to others will not be permitted

Males

1. A shirt must be worn at all times.
2. All flesh between the shoulder area and 3 inches above the knee must be covered at all times
3. No excessively baggy or sagging pants/shorts are allowed
4. Undergarments including Muscle shirts should be covered by clothing and should not be seen
5. Apparel that advertises or depicts alcohol, drugs, nudity, tobacco products, satanic themes, gang membership, obscene language, obscene graphics, and/or phrases that are offensive to others will not be permitted



House Rules

1. Practice common courtesy and respect to peers and staff at all times

- a. Keep hands to yourself, respect each other's personal space.
- b. Avoid name calling or disrespect.
- c. Maintain a reasonable noise level while talking, playing video games, or watching TV.
- d. Ask staff before getting any food or drink from the kitchen.

2. The following items should not be brought

- a. Personal Electronics including:
 - CD Players/Radios
 - MP3 Players
 - Cell Phones
 - Hand held video games
 - Cameras
- b. Entertainment media including:
 - DVDs
 - CDs
 - Video Games
- c. Any item that can be used as a weapon
- d. Cigarette lighter, matches, tobacco products, alcohol, drugs, and other paraphernalia
- e. Permanent markers
- f. Money - no money is needed, staff will provide all activities and refreshments

*** All of these items must be surrendered to staff ***

3. Vehicle Transportation and Safety

- a. Seat belts must be fastened before the van is put in motion and should remain fastened at all times.
- b. Face forward at all times while van is in motion.
- c. Noise level must be low enough that the driver can hear activity outside the van.
- d. Everyone should contribute to van safety by notifying staff of any violation of safety rules.