



Marie's Place CCS: Information for Referring Providers

Please call CCA at (866) 420-9332 (option #5, then #1) to inquire about bed availability and eligibility prior to completing the referral form. Once bed availability & eligibility are confirmed, please:

1. Review the below information about the Marie's Place Community Crisis Stabilization (CCS) program
2. Complete the Marie's Place Community Crisis Stabilization Referral Form (begins on Page 2 below)

Requirements for Admission
Eligibility: CCA members covered under Medicare Advantage or Rhode Island plans are not eligible for admission.
COVID: A negative antigen test within 72 hours of admit; PCR test required if member has had close contact or has symptoms.
BH Evaluation: an evaluation by a licensed Behavioral Health Clinician within the last 24 hours that determined need for CCS.
ADLs: Member must be independent with ADLs; Marie's Place CCS is unable to accept members who require PCA services.
Detox: Marie's Place CCS can administer an uncomplicated alcohol or benzo detox. Marie's Place CCS is unable to provide detox protocols using MAT (methadone, suboxone).
Colostomy/urostomy/or intermittent catheterization needs: Member must be independent with care & arrive with 7-day supply
Weight/bariatric accommodations: Marie's Place CCS has one 1 st floor bed that can accommodate up to 450lbs.
Nurse-to-Nurse: A nurse-to nurse consult is required for members admitting from an Emergency Department.
Repeat Admissions: Please complete the referral form for each admission in case clinical status has changed

Things to inform member prior to arrival
Bring all medications if possible.
Masks are required to be worn for the duration of the admission.
If member is withdrawing from opiates, member will receive comfort measures only.
Controlled substances can take up to 24 hours to fill and are ordered at the provider's discretion.
Wound Care Supplies: Member must come to the unit with a 7-day supply of all supplies and topicals.

Required Supplemental Documents for Referral (as applicable)	
Last dose letter from ED if methadone was administered in ED	Tox screen results (if available)
Lab results (if available) <ul style="list-style-type: none"> • For Coumadin: most recent PT/INR • For Clozaril: recent/current CBC with differential 	COVID PCR Test Results (only required if member has had close contact or has symptoms of COVID)



Marie's Place CCS Referral Form

Submit completed referral form by email to CSUintakes@commonwealthcare.org or fax to (617) 275-8975
 Questions? Call CCA Provider Services at (866) 420-9332 (option #5, then #1)

If any of the below information is included in a BH crisis evaluation (completed within the last 24 hours), include the evaluation with the referral form. Questions may be skipped if the information is in the evaluation. Once the completed referral is received, CCA staff will respond with a determination within 1 hour.

Section I.	Referral Information				Date of Request	
Member Name:	DOB:	Member's LOB:		<i>(CCA Intake Team to complete)</i>		
	Member Phone #:					
Referring Provider Name:	Referring Provider Phone #:					
Will referring provider be available for consult pre-admission (if needed)? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, provide additional contact name & phone #:	ED Nurse Name & Phone # (if member in ED):					
	Date & Time of Evaluation:					
Current Member Location: <small>(Please specify ED or community location)</small>	Member's living situation:	Gender:				
		Preferred Pronouns:				
If member is on Section 12, is referring provider in agreement w/dischARGE to an unlocked, community-based setting? <input type="checkbox"/> Yes <input type="checkbox"/> N/A						
Section II.	COVID-19 Testing & Screening					
Date & Time of COVID Test (Antigen): <small>(CCA requires a negative antigen test within 72 hours of admit)</small>	Test Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative	Test was administered by provider: <input type="checkbox"/> Yes <input type="checkbox"/> No <small>(Test must be administered by provider)</small>				
In the past 2 weeks, has the member tested positive for COVID? <input type="checkbox"/> Yes <input type="checkbox"/> No <small>If yes, must be 10 days since symptom onset/positive COVID test, and member must be fever-free for 24 hours in order to admit</small>						
Has member been in close contact w/someone with COVID with or without PPE? <input type="checkbox"/> Yes <input type="checkbox"/> No					<i>If yes, PCR test required; submit results with referral</i>	
In the past 10 days, has member had any of the following? Fever over 100°, chills, cough, sore throat, difficulty breathing, nausea/vomiting, muscle/body aches, fatigue, diarrhea, headache, loss of taste/smell <input type="checkbox"/> Yes <input type="checkbox"/> No						
Section III.	Presenting Problem & Clinical Presentation					
BH & Medical Diagnoses:						
Presenting Problem/Precipitant:						
Risk Assessment	Suicidality:	<input type="checkbox"/> None	<input type="checkbox"/> Ideation	<input type="checkbox"/> Plan	<input type="checkbox"/> Intent	<input type="checkbox"/> Self-Harm
	Homicidality:	<input type="checkbox"/> None	<input type="checkbox"/> Aggressive	<input type="checkbox"/> Intent	<input type="checkbox"/> Plan	<input type="checkbox"/> Other
	Delusions:	<input type="checkbox"/> None	<input type="checkbox"/> Grandiose	<input type="checkbox"/> Paranoid	<input type="checkbox"/> Religious	<input type="checkbox"/> Other
	Hallucinations:	<input type="checkbox"/> None	<input type="checkbox"/> Auditory	<input type="checkbox"/> Command Auditory	<input type="checkbox"/> Visual	<input type="checkbox"/> Other
	Please describe risk factors as applicable:					
Has member required restraints in the past 24 hours? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:						
Mental Status	Please describe mood, affect, appearance, behavior, insight, judgement, thought process, ADLs, sleep & appetite:					

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Section IV. Medical Needs & Medication Information

Does member have mobility/ambulation challenges? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the member have visual impairment that affects mobility? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, is member able to independently go up/down up to 2 flights of stairs? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, does member use a cane/walker/wheelchair? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does member have a history of seizures? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when was last seizure? Was it witnessed? <input type="checkbox"/> Yes <input type="checkbox"/> No	How often does member have seizures? What type of seizures does member experience?
Does member have any nursing needs? <input type="checkbox"/> Yes <input type="checkbox"/> No	If nursing needs, please describe:
Does member require oxygen or any other medical equipment, including bariatric equipment? <input type="checkbox"/> Yes <input type="checkbox"/> No	If oxygen or DME needs, please describe:
Does member need assistance to complete ADLs? <input type="checkbox"/> Yes <input type="checkbox"/> No	If ADL needs, please describe:
Does member have wound care needs? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify cause, type & location of wound:	Is member on Clozaril? <input type="checkbox"/> Yes <input type="checkbox"/> No Is member on Coumadin? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is member adherent to medications? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain:	Recent medication changes? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:
Is member on any IM medications? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when is next dose due? (if known):	Does member have their medications on hand? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Member is not required to bring medications with them (preference is they bring meds).</i>

Does member have lice or bed bugs? Yes No
If yes, does not prohibit member from admitting; CCS must know ahead of time to prepare for the member's arrival

Section V. Substance Use Info

Has member used substances in past 7 days? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, does member require detox? <input type="checkbox"/> Yes <input type="checkbox"/> No BAL:
If Yes, please describe: substance used, amount, frequency, route of administration, history of overdose	
Is there a history of withdrawal seizures? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is there a history of requiring medical hospitalization related to SUD? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date of most recent admission:
Is member prescribed: <input type="checkbox"/> Suboxone <input type="checkbox"/> Methadone <input type="checkbox"/> Not applicable Dose (if applicable): Prescriber name: Prescriber location:	<u>Methadone Only:</u> Home clinic name: Most recent date of methadone at home clinic: Number of doses given in ED:

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Section VI. Collateral Contact info	
Please provide the collateral contact info for any of the below that are involved in the care of this member (as applicable):	
Prescriber Name:	Prescriber Phone #:
Therapist Name:	Therapist Phone #:
VNA Name:	VNA Phone #:
DMH/DDS Provider Name: Please specify: <input type="checkbox"/> ACCS <input type="checkbox"/> PACT <input type="checkbox"/> DDS	DMH/DDS Provider Phone #:
Group Living Environment Name:	GLE Phone #:
Guardian Name:	Guardian Phone #: