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. Test must be either administered by a provider or the provider needs to observe the member's self-administration of the test. 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 1st 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
Transportation: CCA requires that the referring provider arrange transportation for the member to Marie's Place**.**

Required Supplemental Documents for Referral (as applicable)	
BH Crisis Evaluation	Tox screen results (if available)
Lab results (if applicable) • 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*)
Last dose letter from ED if methadone was administered in ED	

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.

For reference, CCA's CCS Medical Necessity Guidelines can be found at www.commonwealthcare.org

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 a BH crisis evaluation was completed within the last 24 hours, please 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.

Clear Form

Section I. Referral Information		Date of Request
Member First Name: Member Last Name:	DOB: Member Phone #:	Member's LOB: *(CCA Intake Team to complete)*
Referring Provider Name:	Referring Provider Phone #:	
Will referring provider be available for consult pre-admission (if needed)? ☐ Yes ☐ No If no, provide additional contact name & phone #:	ED Nurse Name & Phone # (if member in ED): Date & Time of Evaluation:	
Current Member Location: (Please specify ED or community location)	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: ☐ Yes ☐ N/A		

Section II. COVID-19 Testing & Screening		
Date & Time of COVID Test (Antigen): *(CCA requires a negative antigen test within 72 hours of admit)*	Test Result: ☐ Positive ☐ Negative	Test was administered or observed by provider: ☐ Yes ☐ No *(Test must be administered/observed by provider)*
In the past 2 weeks, has the member tested positive for COVID? ☐ Yes ☐ No *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*		
Has member been in close contact w/someone with COVID with or without PPE? ☐ Yes ☐ No		*If yes, PCR test required; submit results with referral*
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 ☐ Yes ☐ No		

Section III. Presenting Problem & Clinical Presentation

BH & Medical Diagnoses:

Presenting Problem/Precipitant:

Risk Assessment

Suicidality:	☐ None	☐ Ideation	☐ Plan	☐ Intent	☐ Self-Harm
Homicidality:	☐ None	☐ Aggressive	☐ Intent	☐ Plan	☐ Other
Delusions:	☐ None	☐ Grandiose	☐ Paranoid	☐ Religious	☐ Other
Hallucinations:	☐ None	☐ Auditory	☐ Command Auditory	☐ Visual	☐ Other

Please describe risk factors as applicable:

Has member required restraints in the past 24 hours? ☐ Yes ☐ No

If yes, please explain:

Marie's Place CCS Referral Form

Mental Status	Please describe mood, affect, appearance, behavior, insight, judgement, thought process, ADLs, sleep & appetite:

Section IV. Medical Needs & Medication Information

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

Marie's Place CCS Referral Form

Section V.	Substance Use Info	
Has member used substances in past 7 days? ☐ Yes ☐ No	If yes, does member require detox? ☐ Yes ☐ No	
	BAL:	Was tox screen completed? ☐ Yes ☐ No *If yes, please submit results with referral*
If Yes, please describe: substance used, amount, frequency, route of administration, history of overdose:		
Is there a history of withdrawal seizures? ☐ Yes ☐ No	Is there a history of requiring medical hospitalization related to SUD? ☐ Yes ☐ No If yes, date of most recent admission:	
Is member prescribed: ☐ Suboxone ☐ Methadone ☐ 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:	

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: ☐ ACCS ☐ PACT ☐ DDS	DMH/DDS Provider Phone #:
Group Living Environment Name:	GLE Phone #:
Guardian Name:	Guardian Phone #: