To Whom It May Concern:

Thank you for choosing Gull Harbour, part of Thrive Behavioral Network, as a potential placement for you or your client. It is our goal to provide quality person-centered services, enhance stability, and provide a setting where individuals can achieve self-sufficiency and the skills necessary to live more independently in the community. As you may have requested, we are sending you our application packet. This packet includes:

- A Referral Information Form, to gain general information about the individual and assist in determining eligibility for services as defined in 245I.23 Subd. 15.
- Information about our program services and expectations to help you make an informed choice about your treatment selection.
- A blank ROI to assist in expediting care coordination and the referral process.

Supporting information that is helpful and necessary in the successful placement of an individual includes, but is not limited to:

- Current Diagnostic Assessment, Pysch Eval, and/or Functional Assessment (if available)
- Most Recent Treatment Plan, Progress Notes, and/or Discharge Summary
- Current medications list

In addition to the above documentation, an interview may be completed with the individual to ensure they meet all criteria for safe placement in this treatment setting. After a candidate is successfully screened and accepted, a source of payment will need to be secured prior to admission. We will also need signed orders from the attending physician prior to admission and prior to being able to administer any medications.

Our staff members are available to aid you in navigating our referral process. Please call or email us with any questions or concerns, and we will gladly be of assistance:

Email: gullharbour@thrivebn.com
Phone: (218) 233-8068

Please fax the referral form and all supporting documentation to: (218) 287-0581.

Sincerely,

Susan Ahmet
Program Director
Thrive Behavioral Network

Thrive BEHAVIORAL NETWORK LLC
Live well.

INCLUDED IN THIS PACKET

IRTS Programs and Services

INDIVIDUALIZED, COMPASSIONATE, AND PERSON-CENTERED CARE.

Our team members are passionate about what they do and understand and value the importance of delivering services that align with your goals, values, and preferences. Our team members take the time to get to know you, listen to and understand your concerns, and help you make informed decisions about your treatment and overall well-being. We believe that developing trusting relationships with your treating professionals is key to your recovery process.

QUALITY SERVICE DELIVERY FROM QUALIFIED PROFESSIONALS.

Our interdisciplinary treatment teams consist of Mental Health Rehabilitation Workers, Mental Health Practitioners, Mental Health Professionals, Registered Nurses, Certified Peer Specialists, Certified Rehabilitation Specialists, Treatment Supervisors, Program Directors, and a Psychiatric Medical Professional, all who have undergone extensive training and are eager to meet with you to assist you in achieving your wellness goals.

24/7 AWAKE STAFF SUPPORT AND STRUCTURED PROGRAMMING.

Our scheduled programming and structure consist of rehabilitative mental health services, crisis prevention planning, health services and medication administration, co-occurring substance use disordered treatment, family education and engagement services, and therapeutic recreational opportunities. Individual and group counseling is available and tailored to the needs of the individuals being served in our programs. We believe in offering evidenced based practices, which are well-researched interventions that combine clinical expertise with an individual's values and preferences, aimed and assisting you in achieving your treatment goals. Such practices include the use of group and individual interventions from Enhanced-Illness Management and Recovery, Integrated Dual Diagnosis Treatment, Mindfulness, Cognitive Behavioral Therapy, Seeking Safety, and Dialectical Behavioral Therapy. Individuals in our program can expect to attend on average 3 to 5 scheduled groups or structured activities per day, along with a 1:1 encounter with a treatment team member to advance you toward meeting your personal treatment plan goals and objectives.

CARE COORDINATION AND TRANSITION SERVICES.

We believe that recovery is possible and supported through relationships and social networks. Therefore, with your consent, you can expect our team members to invite your family, natural supports, and other treating professionals to be a part of your recovery journey. Likewise, you can expect our treatment team members to provide you with referrals and resources to increase your community support network both throughout your treatment stay with us, and as you prepare to discharge from our services.

For more information about our company or programs, check us out at: https://www.thrivebn.com

Respecting Self

1. Individuals are responsible for actively participating in their treatment process. This includes developing and adhering to their individual treatment plan, completing required assessments, attending programming being offered, engaging in daily 1:1 encounters, and following their prescribed medication schedule. *Note: Medication is to be taken at prescribed times. Medications are to be locked up and administered with staff supervision unless approved by RN for unobserved self-administration.*
2. Non-prescribed drug or alcohol use is not permitted for the duration of the treatment episode. This includes but is not limited to, over the counter mood-or mind-altering substances such as kratom, Delta-8, or K2.
3. Individuals are responsible for their personal cleanliness and well-being.
4. Individuals are expected to be fully clothed when leaving their private rooms, including wearing appropriate footwear.
5. Individuals may not leave the facility grounds without staff approval.

Respecting Others

6. Violence, the threat of violence, or language that is abusive, discriminatory, or harassing in nature, will not be permitted.
7. Individuals in the program will not be allowed to enter others personal space, including entering another individual's private room, or take things from others that do not belong to them.
8. Individuals are expected to know and follow the rights, privacy, and confidentiality of others.

Respecting Facility

9. The privilege of using nicotine is provided in the outside designated smoking areas only. Individuals are expected to use designated urns to properly dispose of cigarette butts and keep the space clean.
10. Quiet hours are observed between the hours of 10:00 p.m. and 7:00 a.m.
11. Meals and snacks are provided. Individuals are expected to eat in designated areas. Individuals may have their own food as space permits unless it interferes with the health and safety of others.
12. Individuals may possess and use their own personal electronic devices if it doesn't interfere with treatment or the rights or privacy of others. No audio or video recording of staff or others in the program is allowed. All media being presented in commons areas is to be mindful of, and support, a trauma informed care environment. *Note: Storage space is limited, and staff are not responsible for lost or broken devices. Individuals are recommended to find alternative storage space for large or expensive devices prior to entering treatment.*
13. Visitors to the program are allowed outside of regularly scheduled programming and mealtimes. Onsite visits require prior notification to the staff in order to ensure adequate visiting space is available. All onsite visits will occur in common areas designated for visitation. Visitors will be asked to sign in/out of the facility through the main entrance as well as to sign a non-disclosure and confidentiality agreement. Only staff are permitted to allow visitors into the building.
14. Only staff is permitted to receive and distribute mail.

CLIENT INFORMATION							
Client Name					**Date**		
DOB		**Age**			**Phone Number**		
Sex	❑ M ❑ F	**Gender Identity**			**Preferred Pronouns**		
SSN				**PMI #**			
Home Address							
Current Location							
Anticipated Discharge from Current Placement				**Preferred Date for IRTS Admission**			
Diagnosis							
Type of Commit	❑ MI	❑ MI/CD	❑ CD	❑ MI & D	❑ Jarvis		
Guardianship / Legal Status							
Referral Name		**Phone**		**Supervisor**			
Case Manager if different than referral source		**Phone**		**Supervisor**			
Community Psychiatric Care Provider							
Inpatient Psychiatric Care Provider							
County of Financial Responsibility		**County Insurance App. Sent To**					
Financial Worker		**Contact Information**					
Monthly Gross Income		**Income Source(s)**					
Reductions to Income amount and reason							

BENEFITS				
❑ MA Open	❑ MA Pending	❑ SMRT Pending	❑ Soc Sec Pending	❑ GAMC
❑ GA	❑ Waiver	❑ RSDI $	❑ SSI $	

Applications Filed	❑ Yes ❑ No	**Support letter for benefits applied for from physician**	❑ Yes ❑ No

CURRENT HOUSING RESOURCES				
❑ Bridges	❑ S & C	❑ Section 8	❑ CAP Apt	❑ Other Housing Resources

INSURANCE					
Name of Plan		**Type of Plan**			
Plan# or Consumer ID #					
R&B Contribution to IRTS if any		**Client Agrees**	❑ Yes ❑ No		

GOALS FOR PLACEMENT

ADDITIONAL INFORMATION PERTINENT TO IRTS PLACEMENT (support system, cultural considerations, etc.)

THE FOLLOWING INFORMATION WILL BE REQUIRED PRIOR TO INTAKE

❑	If referent is on a stay of commitment or full commitment, a copy of the court findings which indicate the type of commitment/Jarvis as well as a copy of the provisional discharge.
❑	A copy of all current assessments *such as a Diagnostic Assessment, Psych Eval, Functional Assessment and/or LOCUS, and any progress notes, discharge summaries* or other relevant client information to assist in placement determinations.
❑	10-day supply of medication and signed orders from the attending physician for all prescribed medications. Also, any medications requiring **Pre-Authorizations** need to be completed prior to admission to facility.
❑	***For our Willow Haven location only:*** A copy of physical exam or communicable disease determinations completed within 30 days of admission and signed by a provider, OR exam appointment is scheduled within 3 days of admission.

Admission determinations will be made within 72 hours of receiving all pre-admission materials as outlined by 245I.23 Subd. 17

CLIENT INFORMATION							
First Name		**MI**		**Last Name**			
Date of Birth		**Previous Name(s)**					
Address				**Phone Number**			
City		**State**		**Zip**			

AUTHORIZATION TO PERSONS/AGENCIES	
I hereby authorize	I hereby authorize PERSON/AGENCY releasing info:
▪ Thrive Behavioral Network I, LLC, ▪ Thrive Behavioral Network II, LLC, ▪ Thrive Behavioral Network III, LLC, ▪ Thrive Behavioral Network IV, LLC, ▪ Thrive Behavioral Network V, LLC, ▪ Grand Falls Maintenance Company	
Doing Business As	To release information to
	▪ Thrive Behavioral Network I, LLC, ▪ Thrive Behavioral Network II, LLC, ▪ Thrive Behavioral Network III, LLC, ▪ Thrive Behavioral Network IV, LLC, ▪ Thrive Behavioral Network V, LLC, ▪ Grand Falls Maintenance Company
To release information to PERSON/AGENCY receiving info:	
	Doing Business As

CHECK THE REASON(S) FOR RELEASING INFORMATION

- ❑ Treatment/care planning
- ❑ Service Coordination
- ❑ Review current care
- ❑ Payment for services
- ❑ Legal
- ❑ Health insurance application
- ❑ Application or appeal of application for Social Security Disability benefits
- ❑ Marketing
- ❑ Other:

SELECT INFORMATION FOR RELEASE

Release checked documents that were/are produced during these dates: _____ to _____

Health Care Records

- ❑ All Health Care Records (to include any information about you related to mental health evaluation and treatment,concerns about drug and/or alcohol use, HIV/AIDS testing and treatment, sexually transmitted diseases and genetic information)
- ❑ Specific health care records as indicated here:

Mental Health and/or Chemical Dependency Records:
(Chemical Dependency Records only if Special Consent indicated below, not to include psychotherapy notes)

- ❑ Functional Assessment
- ❑ Diagnostic Assessment
- ❑ LOCUS
- ❑ Treatment Plan
- ❑ Progress Notes
- ❑ Progress Reviews
- ❑ Discharge Summary
- ❑ Chemical Dependency Comprehensive Assessment/Summary

Residential, School, or Community Support and Social Services

- ❑ Assessments
- ❑ Community/Residential Support Plan
- ❑ Individualized Education Plan
- ❑ Progress notes
- ❑ Progress Reviews
- ❑ Discharge Summary

Information Requiring Special Consent by Law
(You must specifically request the following information in order for it to be released)

- ❑ Psychotherapy notes (if requesting these records, it must be a separate release where only this item is checked and no other documents)
- ❑ Chemical Dependency Assessment or Treatment Records (Records related to the specific assessment and treatment of alcohol or drug addictions)

Verbal Communication

- ❑ Permission is granted for verbal communication about my health/mental health care between parties identified above.
- ❑ Exchange selected documents only. No verbal communication.

Please understand and acknowledge that by signing this form:

You are requesting that confidential information be exchanged between the agencies or persons listed. You may stop this consent at any time by writing to any organization, facility, and/or professional listed above. You understand that health information released may include information about HIV/AIDS. You may inspect the records being released, or request a copy. You may be charged a fee for copies. You understand that once the information specified above is sent, it could be re-disclosed by the person that receives it and/or may no longer be protected by federal or state privacy laws. You understand that if the organizations listed are health care providers they will not condition treatment, payment, enrollment or eligibility for benefits on whether you sign this consent form. If you choose not to sign this form to release information to an insurance company, your failure to sign will not impact your treatment; but that you may not be able to get new or different insurance; and/or may not be able to get insurance payment for your care.

I understand that my alcohol and drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 Code of Federal Regulations (CFR) Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR,Parts 160 and 164, and cannot be disclosed without my written consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

Choose the expiration date of this release:

- ❑ I understand that this consent will expire in one year from the date signed
- ❑ **OR**, I want this consent to expire on the following earlier date or event:

_____ _____

Client Date

_____ _____

Legal Representative Date

_____ _____

Staff Witness Date