Bremwood Residential Treatment Center
PO Box 848
106 16th St. SW
Waverly, IA 50677
Office 319-859-3547, Fax: 319-352-0773

Your child will be placed on our PMIC waiting list once this application is returned.

Referral Application

Date: _____

Child's name: _____ Date of Birth: _____

Child's current placement: _____

If out of home placement, when was your child placed at this location? _____

Social Security #: _____ County child is from: _____

Height: _____ Weight: _____

Does your child have Title 19 (Medicaid)? _____ Medicaid # _____

MCO(Check) ☐ United ☐ AmeriGroup ☐ AmeriHealth ☐

MCO ID#_____

Is this a Medipass arrangement? ____ if so, please who is the Primary doctor:

Name _____, City _____, Phone# _____

Is your child covered by another insurance policy (such as Blue Cross or Hawk-i)? _____

Name of insurance company: _____ Plan: _____

Policy holder's name: _____ DOB: _____

Employer: _____ Policy #: _____

Employer phone number: _____

Family Information

Mother: _____ Phone #: _____

Address: _____

Father: _____ Phone #: _____

Address: _____

Estimated family Income: _____

If applicable:

Stepfather: _____ Phone #: _____

Stepmother: _____ Phone #: _____

Siblings, DOB: and current living arrangements:_____

_____

Additional family information: _____

_____

Service Worker Contacts

Does your child have a DHS worker? _____

DHS worker's name: _____ Phone #: _____

Address: _____

Does your child have a Juvenile Court or Probation Officer? _____

Name: _____Phone #: _____

Address: _____

Is your child under a court order____ No, _____Yes, CINA_____ or Delinquent _____

Please list any individuals / organizations that work(ed) with you, your family and your child regarding mental health concerns:

Out-patient therapy:

Name / Agency: _____ Phone #: _____

Date started: _____ Date ended: _____

Psychiatric or medication management:

Name / Agency: _____ Phone #: _____

Date started: _____ Date ended: _____

Hospital stay:

Name / Agency: _____ Phone #: _____

Dates: _____

In-patient stays (PMIC, Residential Treatment, Mental Health Institute [MHI])

Name / Agency: _____ Phone #: _____

Dates: _____

Other: In home services such as Behavioral Health Intervention Services or FSRP

Name / Agency: _____ Phone #: _____

Dates: _____

Pediatric Integrated Health or other:

Name / Agency: _____ Phone #: _____

Dates: _____

Comments regarding previous treatment (progress or willing to follow through):

_____

_____

_____

_____

Psychiatric and Medical Information

What is your child's mental health diagnosis (s)?

_____

_____

What are your child's current medications and dosages?

_____ _____

_____ _____

_____ _____

_____ _____

Does your child have any medical conditions? _____

Please list: _____

_____

School Information

School: _____ Phone #: _____

Address: _____

Grade level: _____

Does your child have an IEP? Please check one LD☐ BD☐MD☐Level 1☐ Level 2☐ Level 3☐

What does your child's behavior look like while at school?

_____

_____

Reason for Referral and Goals

Why are you referring your child to Bremwood? (Please include specific behaviors and add additional sheets of paper if necessary). Please include any past or current behaviors that include running away, self-harm, substance abuse, sexual acting out, or aggression.

_____

_____

_____

_____

_____

_____

_____

_____

Emotional triggers for your child:

__being touched __being isolated __bedroom door open

__people in uniform __particular times of the day __AM __mid-day __PM

__times of the year; when _____

__loud noises __ yelling

__any others: please describe_____

Coping techniques your child uses:

__voluntary time alone __listening to music __reading a book

__sitting by an adult __watching TV/movies __talking to a peer

__walking around __writing a letter __talking to an adult

__playing a game __calling a therapist __punching a pillow

__doing hands on projects __writing in a journal __exercising

__deep breathing __going for a walk __taking a hot shower

__laying down __being outside __other _____

Trauma history:

___ sexually abused: if yes, by whom and age, duration:_____

___physically abused: if yes, by whom and age, duration:_____

___sexually abuse someone else: duration, if yes, who?_____

___physically abuse someone else? Duration, If yes, who? _____

___has witnessed physical or sexual abuse? What age, duration and explain: _____

_____

___has experienced emotional abuse? By whom, duration and age: _____

___ever experienced verbal abuse, ex. Name calling, etc.:_____

___any other trauma such as, divorce death of a family member, car accident, neglect, rape, etc. _____

What type of involvement is your family willing to participate in during your child's treatment?

_____

Family history of mental health issues:

Paternal side: _____

_____

Maternal side: _____

_____

Will your child go home after treatment? _____

If not, where will your child go? _____

What goals do you hope your child accomplishes while in treatment?

_____

_____

What goals would your family like to accomplish while your child is receiving treatment?

_____

_____

_____

Where did you learn about Bremwood? _____

Additional Comments:

_____

_____

_____

_____

_____

Please print name: _____

Signature: _____

Relationship to the child: _____

E-mail:_____

Please return completed form to:

Rachel Calkins
Bremwood Intake Specialist
PO Box 848
Waverly, IA 50677
Rachel.Calkins@lsiowa.org
319-859-3547

TEAM CERTIFICATION OF NEED FOR
PSYCHIATRIC MEDICAL INSTITUTIONS FOR CHILDREN LEVEL OF CARE

Name of Child	Birthdate

INDEPENDENT TEAM ASSESSEMENT

YES NO (All criteria must be checked for PMIC level of care)

☐ ☐ 1. Available alternative local community resources for ambulatory care do not meet the treatment needs of this individual.

☐ ☐ 2. Proper treatment of this individual's psychiatric condition requires service on an inpatient basis, under the direction of a physician.

☐ ☐ 3. These services can reasonably be expected to improve this individual's condition or prevent regression so that services will no longer be needed.

TREATMENT TEAM

Physician signature	Signature Date
Licensed Psychologist signature	Signature Date
Registered Nurse signature	Signature Date
Social Worker signature	Signature Date
Occupational Therapist signature	Signature Date

Lutheran Services in Iowa, Inc
Third Party Insurance Verification Form

Section I: Record Available Demographic and Pre-Authorization Information

Client Name _____
Title 19/Medicaid #_____

Client DOB _____

Client SS# _____
Enrollment Date _____

Questions to ask the client/parent/guardian prior to admission/enrollment:
Did you contact your insurance company to verify your benefits and let them know you will be receiving treatment services? Yes_____ No_____
Did you receive an authorization from your insurance company? No_____ Yes_____
(obtain a copy and provide details below)
Authorization # _____ # Visits/Length of Stay _____

Section II: Obtain Primary Insurance Information (attach copy of both sides of member's insurance card)

Insurance Company _____
Insured Name _____

Insurance Phone # _____
Relationship to Client _____

Claims Address _____
Insured Phone _____
Insured Address _____

Policy Number _____

Group Number _____
Insured DOB _____

Member Number _____
Insured SS# _____

Employer: _____
Employer Phone #:_____