To Whom It May Concern:

Thank you for choosing Austin Manor, part of Thrive Behavioral Network, LLC, 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:

- Referral Information to gain general information about the individual.
- LOCUS Assessment Form. This along with a recently completed Functional Assessment helps us to determine that IRTS is the correct level of care for the individual.
- Daily Schedule of activities for this program so the individual can see what their daily routine might look like.

A Professional Statement of Need form (download here) must be completed by a qualified professional.

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

- Current Diagnostic Assessment
- Most Recent Treatment Plan, Progress Notes, and/or Discharge Summary

In addition to the above documentation, a clinical interview may be completed with the individual to ensure they meet all criteria for placement in this treatment setting. After a candidate is successfully screened and accepted, a placement agreement (typically with the county of financial responsibility) will be completed prior to admission.

Our staff members are available to aid you in navigating our referral process, which can be confusing at times. Please call with any questions or concerns, and we will gladly be of assistance.

Sincerely,

Rachel Weigel
Treatment Director
Thrive Behavioral Network, LLC
Rachel.Weigel@thrivebn.com
(P) 507.433.5569 (F) 507.434.4707

Thrive BEHAVIORAL NETWORK LLC
Live well.

INCLUDED IN THIS PACKET

Minnesota Department of **Human Services**

DHS-6249-ENG 10-10

LOCUS Recording Form

DATE OF ASSESSMENT	DIAGNOSIS	
RECIPIENT DATE OF BIRTH	RECIPIENT GENDER ☐ Male ☐ Female	RECIPIENT PMI or SOCIAL SECURITY NUMBER
PROVIDER NAME	PROVIDER NPI	SERVICE TYPE
ACTUAL LEVEL OF CARE PROVIDED		
SERVICE(S) RECIPIENT IS RECEIVING OR REFERRED TO		
REASON FOR VARIANCE (if applicable)		

I. Risk of Harm
- ☐ 1. Minimal
- ☐ 2. Low
- ☐ 3. Moderate
- ☐ 4. Serious
- ☐ 5. Extreme

II. Functional Status
- ☐ 1. Minimal
- ☐ 2. Mild
- ☐ 3. Moderate
- ☐ 4. Serious
- ☐ 5. Severe

III. Co-Morbidity
- ☐ 1. None
- ☐ 2. Minor
- ☐ 3. Significant
- ☐ 4. Major
- ☐ 5. Severe

IV-A. Recovery Environment – Level of Stress
- ☐ 1. Low
- ☐ 2. Mildly
- ☐ 3. Moderately
- ☐ 4. Highly
- ☐ 5. Extremely

IV-B. Recovery Environment – Level of support
- ☐ 1. Highly Supportive
- ☐ 2. Supportive
- ☐ 3. Limited Support
- ☐ 4. Minimal Support
- ☐ 5. No Support

V. Treatment and Recovery History
- ☐ 1. Full Response
- ☐ 2. Significant Response
- ☐ 3. Moderate or Equivocal Response
- ☐ 4. Poor Response
- ☐ 5. Negligible Response

VI. Engagement
- ☐ 1. Optimal
- ☐ 2. Positive
- ☐ 3. Limited
- ☐ 4. Minimal
- ☐ 5. Unengaged

COMPOSITE SCORE

LEVEL OF CARE RECOMMENDATION

NAME AND CREDENTIALS OF WHO COMPLETED	SIGNATURE	DATE
NAME OF CLINICAL SUPERVISOR (MH PROFESSIONAL)	SIGNATURE	DATE

As a mental health provider in the State of Minnesota, Deerfield Behavioral Health, Inc. is granting you permission to scan this completed LOCUS Recording Form, where the dimensional scores, criteria, composite score and level of care recommendation have been documented, into your electronic medical record.

Instructions for completing the LOCUS Recording Form

Date of Assessment
The date the LOCUS assessment was completed.

Date of Birth
Month/Day/Year (MM/DD/YYYY)

Gender
Male or Female

Recipient PMI or Social Security number
PMI number is preferred over the social security number.

Diagnosis
Primary (Write in the full diagnostic name of the primary diagnosis or use the ICD-9 code).

Provider Name, NPI and Service Type
NPI number and the name of the organization completing the LOCUS and what type of service is being provided by the staff completing the LOCUS assessment.

Actual Level of Care
What is the actual Level of Care the recipient is receiving? Write the actual name of the level (i.e. Medically Monitored Non-Residential). It may not necessarily be the same as the 'Level of Care Recommendation' if a variance is being made.

Service/Program Referred to
Write the current program(s) recipient is in or what program(s) recipient has been referred to (example: ARMHS, Day Treatment, Case Management, Psychiatry, housing programs, etc.). Please keep in mind that there may be multiple services used to reach an individual's resource intensity needs.

Reason for Variance (if applicable)
If the service provided is at a different level of care from the level of care recommendation, provide the brief clinical justification as to why the variance was made. Clinical justification also needs to be documented in more detail as a separate document from the recording form.

➔ In the dimension being evaluated please **check** which rating was given. On the line following the rating please indicate the **letter(s)** of the criteria that was used to determine the score. This information can be located in the **AMHD LOCUS Questionnaire Booklet** or in the training manual.

Composite Score
Add up the score from each dimension to determine the composite score.

Level of Care Recommendation
From the score and use of the decision tree, what is the Level of Care recommended. Write the actual name of the level (i.e. Medically Monitored Non-Residential)

NOTE: the Level of Care recommendation may be different from the composite score if Independent Criteria is indicated that requires admission to a Level 5 or Level 6 service. It may also be different if clinical judgment is used in determining that a different level of care is more appropriate than what the completed LOCUS assessment recommends.

Signature spaces
Signature spaces are located at the bottom of the page on the LOCUS Recording Form. If a Mental Health (Rehab) Professional is completing the LOCUS assessment, there **does not** need to be a signature by a clinical supervisor.

Attach Current LOCUS, Diagnostic Assessment, and Functional Assessment

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.
❑	Copy of physical exam, completed and signed by a provider OR exam appointment has been scheduled within 30 days. A copy of all current assessments *including the LOCUS*.
❑	3-day supply of medication and current scripts for all medications. Also, any medications requiring **Pre-Authorization** need to be completed prior to admission to facility.

Admission decisions will be made within 72 hours of receiving all pre-admission materials as outlined by R36V.11

<table>
<tr><th>TIME</th><th>MONDAY</th><th>TUESDAY</th><th>WEDNESDAY</th><th>THURSDAY</th><th>FRIDAY</th><th>SATURDAY</th><th>SUNDAY</th></tr>
<tr><td>8:30 AM</td><td>Wake-up & Medication</td><td>Wake-up & Medication</td><td rowspan="2">Staff Meeting</td><td>Wake-up & Medication</td><td>Wake-up & Medication</td><td>Wake-up & Medication</td><td>Wake-up & Medication</td></tr>
<tr><td>9:30 AM</td><td>E-IMR</td><td>E-IMR</td><td>E-IMR</td><td>E-IMR</td><td rowspan="2">Morning Meeting then Free Time</td><td rowspan="2">Morning Meeting then Free Time</td></tr>
<tr><td>11:00 AM</td><td>Mindfulness</td><td>Creative Arts</td><td>E-IMR</td><td>Creative Cooking</td><td>Writers Group</td></tr>
<tr><td>12:00 PM</td><td colspan="7">Lunch Prepared by Each Participant Individually</td></tr>
<tr><td>1:00 PM</td><td>Recreational Group</td><td>Resident Council</td><td>Social Skills</td><td>Mental Health Game</td><td>Family Group</td><td>Personal Needs Shopping</td><td>Deep Cleaning</td></tr>
<tr><td>2:00 PM</td><td>Bank / Gas</td><td rowspan="2">The Bridge</td><td>Library</td><td rowspan="2">Free Time</td><td>Bank / Gas</td><td rowspan="2">Library</td><td rowspan="2">The Bridge</td></tr>
<tr><td>3:00 PM</td><td>Free Time</td><td>Free Time</td><td>Free Time</td></tr>
<tr><td>4:00 PM</td><td colspan="7">Household / Nutrition</td></tr>
<tr><td>5:00 PM</td><td colspan="7">Dinner Preparation Rotates by Apartment (Completed under staff supervision)</td></tr>
<tr><td>6:00 PM</td><td>Mindfulness / Yoga</td><td>IDDT</td><td>WRAP</td><td>Nursing Group</td><td>IDDT</td><td>Evening Meeting</td><td>Evening Meeting</td></tr>
<tr><td>7:00 PM</td><td colspan="7">Active Independent Living Skills Practice and Social Recreational Activities
AA/NA, Rec Center, House Activities, Etc.</td></tr>
<tr><td>8:00 PM
To
10:00 PM</td><td colspan="7">Medications / Free Time</td></tr>
</table>

**** Family psycho-educational sessions to be scheduled in advance.**