Volunteers of America
Minnesota

Omegon Residential Treatment Services
2000 Hopkins Crossroads Minnetonka MN 55305
952-541-4738 www.voamn.org

Dear Parent/Guardian,

Thank you for your interest in Omegon! We are a 3-9 month residential program located in Minnetonka, MN that works with adolescent males and females going through the unique challenges of mental health crisis and drug use.

We understand it can be challenging to navigate the search for treatment. We genuinely care about each child referred to our program and it is our hope that each child is admitted to a program that meets their needs. We do not accept every child referred to our program for this very reason. We want to see children be successful in their journey!

If your child is denied, we will make recommendations as to where we believe your child would most likely be successful based on the information we have. If it seems as if our program would meet your child's needs, we will let you know and give you an estimated wait time for admission. Parents/guardians are required to accompany the child to the intake meeting. Social workers and probation officers are also encouraged to attend.

A question we often get is "What if my child doesn't want to attend long term residential treatment?". In our experience, children who are not aware of how long our program is before the day of admission often experience increased stress when finding out. This can damage your child's trust in you as well as with the Omegon treatment team and sets them back from starting treatment off on the right foot. If you're unsure how to tell your child, you can work together with your child's current provider on how best to share this information with them. Please also feel free to give me a call to talk about your options.

We believe that support from family members as well as involvement in family therapy is crucial to a child's success at Omegon. Family therapy is a mandatory 4 hours a month, and attendance in our parent support group is strongly encouraged (2 hours a month). Once family therapy is initiated, your child can begin to earn short passes out into the community with family members, and eventually can work up to earning weekend passes home.

Please fill out the attached application and include it with the rest of the clinical information we need to begin the referral process. Please don't hesitate to contact me if you have questions about the admission process or about our program!

Jennifer Padden, MA

952.945.4105

Jennifer.padden@voamn.org

Intake Coordinator, Omegon Residential Treatment Center

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Client Information			
First Name:	Middle:		Last Name:
Date of Birth:	Age:	Sex:	SSN:
Address:			Phone:
City:		State:	Zip Code:
Ethnicity:	Religion:		Language(s) spoken:
Where is the child being referred currently residing?			
Parent/Guardian Information			
Mother's Name:		DOB:	SSN:
Address:			Phone:
			Email:
Father's Name:		DOB:	SSN:
Address:			Phone:
			Email:
Guardian's Name:		DOB:	SSN:
Address:			Phone:
			Email:
Is the child adopted? ☐ Yes ☐No At what age?			
Custody (Complete if parents do not reside together)			
Legal Custody: ☐ Mother ☐ Father ☐ Joint ☐ Other (specify):			
Physical Custody: ☐ Mother ☐ Father ☐ Joint ☐ Other (specify):			
☐ I have provided a copy of custody paperwork (if applicable). _____ (initials)			
County Information			
Social Worker Name:			County:
Address:			Phone:
Email:			Fax:
Probation Officer Name:			County:
Address:			Phone:
Email:			Fax:
Children's Mental Health case manager:			County:
Address:			Phone:
Email:			Fax:
Rule 25 Authorizer (if applicable):			County:
Address:			Phone:
Email:			Fax:
Insurance Information			
Primary Health Insurance:			Subscriber name:
Policy or ID#		Group:	Phone:
Secondary Health Insurance:			Subscriber name:
Policy or ID#		Group:	Phone:
Dental Insurance:			Subscriber name:
Policy or ID#		Group:	Phone:
Pharmacy:			Phone:
Medical Assistance # (if applicable):			

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Clinical Information	
Presenting Problems (what has happened to prompt the search for treatment now):	
Does the client have a history of trauma/abuse? □ Yes □ No Please explain:	
Is this client a danger to self?	□ Yes □ No
Is this client a danger to others?	□ Yes □ No
Is this client at risk of running away from treatment?	□ Yes □ No
Does this client have a history of physically assaulting anyone?	□ Yes □ No
Does this client have a history of property destruction?	□ Yes □ No
Does this client have a history of perpetrating sexual abuse?	□ Yes □ No
Does this client have a history of eating disorder behaviors?	□ Yes □ No
□ Restricting □ Purging □ Other (please specify):	
If you answered "yes" to any of the above questions, please provide details:	
Current MH Professional/Therapist:	Phone:
Address:	Fax:
Current Psychiatrist:	Phone:
Address:	Fax:
Date and location of most recent psychological/neurological testing:	

Treatment History		
Type of Setting: □outpatient □inpatient □ hospital □ day treatment	Provider Name:	Estimated dates of service:
Type of Setting: □ outpatient □ inpatient □ hospital □ day treatment	Provider Name:	Estimated dates of service:
Type of Setting: □ outpatient □ inpatient □ hospital □ day treatment	Provider Name:	Estimated dates of service:
Type of Setting: □ outpatient □ inpatient □ hospital □ day treatment	Provider Name:	Estimated dates of service:
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Medications/Medical		
Name:	Dosage:	Purpose:
Name:	Dosage:	Purpose:
Name:	Dosage:	Purpose:
Name:	Dosage:	Purpose:
Dr prescribing these meds:		Phone:
Address:		Fax:
Has the client ever had a seizure? □ Yes □ No	On seizure meds? □ Yes □ No	Date of last EEG:
Does the client have Diabetes? □ Type 1 □ Type 2	On diabetes meds? □ Yes □ No	Medication name:
Has the client broken a bone in the last month?		□ Yes □ No
Does the client currently have braces on teeth?		□ Yes □ No
Has the client ever had a positive Mantoux (Tuberculosis) test?		□ Yes □ No
Does the client have any food or drug allergies?		□ Yes □ No Are any life threatening? □ Yes □ No
List allergies/reactions:		
Any special dietary requirements? □ Yes □ No	Please Explain:	
Has the client ever had asthma? □ Yes □ No	Last time they needed an inhaler:	
List any serious, chronic or communicable diseases?		□ Yes □ No Please explain:
Any cardiac issues? □ Yes □ No	Please Explain:	Date of last EKG:
Does the client have mobility issues?		□ Yes □ No
If yes, please explain:		
Primary Care Physician/Clinic:		Phone:
Address:		Fax:
Dentist/Dental clinic:		Phone:
Address:		Fax:
Please list all current and previous medical diagnoses:		
Educational Information		
Last school attended:		Current Grade:
Address:		School contact person:
Home School District:		IQ:
Individualized Education Plan (IEP)? □ Yes □ No	If yes, please attach a copy and IEP evaluation for our records	
Legal Information		
Is the client court ordered to attend treatment?	□ Yes □ No	If yes, please attach a copy of court order
Client's attorney (if applicable):		Phone:
Does the client have assault charges?	□ Yes □ No	
Please briefly describe all legal charges or pending charges:		
Motivation		
Does the client believe they have a problem with drugs and/or alcohol?		□ Yes □ No
Does the client want help getting sober?		□ Yes □ No
Does the client know someone is looking into long term treatment for them?		□ Yes □ No
Does the client know Omegon's length of stay is 3-9 months (average 4-6 months)?		□ Yes □ No
Is the family/guardian willing to participate in 4 hours of family therapy a month?		□ Yes □ No
Does the family/guardian know Omegon is **not** a locked facility?		□ Yes □ No
Name of person filling out application:	Signature:	Date:

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Referral Information Checklist

For a timely review, please provide Omegon with ***all*** the below information when making a referral:

☐ Completed attached 3 page application

☐ Relevant legal documentation (custody papers, court orders etc)

☐ Copies of insurance cards (medical, dental, prescription)

☐ Clinical information including:

- ☐ Rule 25 or chemical dependency assessments
- ☐ Most recent psychological/psychiatric assessment/diagnostic assessment (must have been completed in the last 6 months)
- ☐ Treatment summaries and recommendations from prior treatment (hospital, inpatient, outpatient etc)
- ☐ Psychological/Neuropsychological testing

☐ Most recent Individualized Education Plan (IEP) including testing/evaluation done by the school (if applicable)

☐ Immunization records

☐ Physical signed by a medical doctor or nurse practitioner (this can be completed after referral but ***must*** be completed before admission to Omegon)

Please send all the above information by email, fax or mail to:

Omegon Residential Treatment Center Attn: Jennifer Padden

Direct: 952.945.4105, Main: 952.541.4738

Fax: 888.965.5128

Email: Jennifer.padden@voamn.org

Mail: 2000 Hopkins Crossroad, Minnetonka, MN 55305

Please note that incomplete applications/information will not be considered for placement. Due to the high volume of referrals we receive, only complete information on a child will be reviewed.