Nebraska Configuration Form

* Required

Select a Form Type

Referring Organization
Sending referrals to receiving organizations is the primary function of this organization type. There is no limit to the amount of referring users that can be added to this organization

Receiving Organization
Receiving referrals is the primary function of this organization type. There is no limit to the amount of receiving users that can be added to this organization. There are three build options available. (If interested in learning more about these build types, please reach out to onboarding@bam-boohealth.com before filling out this form.)

1. What type of form will you be completing for your organization? *

- ◯ Referring Organization Form
- ◯ Receiving Organization Form

Referring Administrator Information

Referring Administrator:

- Primary Functions:
  - Making referrals to Receiving Organizations
  - Managing Referring Organization Users (Referring Administrators and Referring Providers)
  - Pulling reports for Referring Organizations
  - Training new staff on OpenBeds Usage

2. First Name *

3. Last Name *

4. Work Email *

Organization Information

Please fill out all according information as it pertains to your organization.

5. Organization Name *

6. Organization Phone Number *

7. Organization URL

8. Organization Address *

9. City *

10. State *

11. Zip *

The value must be a number

12. Organization Type *

- Medical Facility
- Crisis Service
- Justice System
- State Authority
- Psychiatric Inpatient
- Housing
- Substance Use Inpatient
- Outpatient Treatment Facility
- Practitioners

Receiving Administrator Information

Receiving Administrator:

- Primary Functions:
  - Managing Receiving Organization Users (Receiving Administrators and Receiving Providers)
  - Managing Receiving Organizations Services
  - Pulling reports for Receiving Organizations
  - Training new staff on OpenBeds Usage
  - Updating Availability for Services
  - Responding to referrals

13. First Name *

14. Last Name *

15. Work Email *

Receiving Organization Information

Please fill out all according information as it pertains to your organization.

16. Organization Name *

17. Organization Phone Number *

18. Organization URL

19. Organization Address *

20. City *

21. State *

22. Zip *

Service Details 1

It is required to fill out the below information per each primary service; if your organization has more than one primary service please fill out the according information for each service:

23. Which Service are you describing? *

(Must select ONE service)

- ◯ Crisis Service
- ◯ Psychiatric Inpatient

24. Additional Services

If your treatment organization offers the below services in the primary service (treatment program), please select from the options below. Multiple answers are accepted however, question 24 is not required to continue.

- ☐ Peer Support Services
- ☐ Crisis Service
- ☐ Psychiatric Inpatient
- ☐ Telehealth

25. Service location address *

One service address is required, multiple addresses not accepted

26. City *

27. State *

28. Zip *

29. Service phone number *

30. Dedicated email address to receive referrals *

Email stated here will receive referral notifications, multiple emails not accepted.
Centralized intake email or distribution email account is recommended.

31. Substances treated in Primary Service

- [ ] All
- [ ] Alcohol
- [ ] Cocaine
- [ ] PCP
- [ ] Hallucinogens
- [ ] Inhalants
- [ ] Benzodiazepines
- [ ] Tobacco/nicotine
- [ ] Methamphetamine
- [ ] Heroin
- [ ] Other Opioids
- [ ] Stimulants
- [ ] Dextromethorphan

32. Special Populations

Notate any special populations that are accepted at this service. If your service specializes in any of the below population please only notate that special population.

- [ ] All
- [ ] Adults
- [ ] Children and Adolescent
- [ ] Homeless
- [ ] Pregnant
- [ ] Military and Veterans
- [ ] Gender-Specific: Men or Women
- [ ] Geriatric
- [ ] Criminal Justice
- [ ] COVID
- [ ] LGBTQ

33. Gender and Age Focused *

- [ ] All
- [ ] Adults - Male
- [ ] Adults - Female
- [ ] Youth (17 and under) - Male
- [ ] Youth (17 and under) - Female
- [ ] Children 12 and under

34. Providers on Site

- [ ] Physicians on site
- [ ] Psychiatrist on site
- [ ] Case Manager
- [ ] Peers
- [ ] Allied medical practitioner on site
- [ ] None

35. Difficult to place medical and psychiatric conditions

- [ ] Complex medical conditions
- [ ] Combative or Violent tendencies
- [ ] Actively Psychotic Clients
- [ ] Intellectual/Development Disability
- [ ] Dementia
- [ ] Risk of self harm

36. Payments Accepted

- [ ] All
- [ ] Region funded/self-pay
- [ ] Sliding fee scale
- [ ] Straight Medicaid
- [ ] Medicare
- [ ] Nebraska Total Care
- [ ] Federal military insurance
- [ ] Private health insurance
- [ ] Wellcare
- [ ] United Health Care

37. Service Details: Enter number of overall beds, outpatient treatment slots or walk-in access hours, and pertinent inclusion and exclusion criteria: **no more than 200 characters.** *

38. Hours during which you will accept digital referrals (I.e., M-F 9am - 5pm , S-S 10am - 4pm) *