The Purpose

The transition home offers an additional layer of support to the person who may need a greater amount of time for development of a complicated discharge plan and related system of supports.

The Adult Transition Home works collaboration with the statewide REACH programs. The ATH follows the same overarching goal of stabilizing the person in his/her home and developing prevention services to address future concerns, followed by supporting the person in their transition to a new placement with the best support plan in place to promote success and reduce need for future transitions.

QUESTIONS

To find out more about the ATH Program and whether someone you know would qualify for services, please contact Leigh Anne Zylstra, MSW, LMHP-E ATH Admission/Discharge Coordinator, at (804) 661-8292, or LeighAnne.Zylstra@rbha.org.

ATH is operated by RBHA, an Equal Opportunity Employer.

ATH
Adult Transition Home

Service Information

6310 Hickory Road
S. Chesterfield, VA 23803
Phone: 804.312.8278
Fax: 804.590.1020

ADMISSION CRITERIA

All individuals receiving services must be aged 18 or older and have a diagnosis of a Developmental Disability with co-occurring mental illness and/or significant behavioral challenges.

The referral to the ATH must include rationale why the individual cannot continue to be supported in the REACH Crisis Therapeutic Home or if in a psychiatric hospital or jail, reasons that a person cannot be stepped down to his/her community residence or REACH CTH.

All individuals must meet general admission criteria to the REACH program prior to being considered for admission. An individual requesting a step-down admission from a state psychiatric hospital must be listed on the "Exceptional Barriers List (EBL)".

The transition home does not serve individuals who are actively abusing substances or requiring medically managed detox treatment. The transition home is not intended to be a long-term residence or respite. The transition homes are unable to directly accept individuals who have met criteria for a TDO by an Emergency Service certified pre-screener. No qualifying individual will be turned away if unable to pay.

ADMISSION REQUEST PROCESS

Admission to the transition home is in adherence to all state licensing standards. Information and documentation requested for an admission is standardized across both transition homes.

All referrals for an individual requesting a transfer from a CTH or a step-down admission from a state psychiatric hospital/jail are to be forwarded to the respective Adult Transition Home Admissions/Discharge Coordinator for processing.

ADMISSION DECISION PROCESS

Prior to an admission decision a completed referral package must include the following:

- Referral Form
- Psychological or other Eligibility Documentation
- PCP/Diagnostic Study/Comprehensive Assessment
- Guardianship Documentation

Once received, an Admission Advisory Committee meeting will be scheduled to review the case.

ADMISSION PAPERWORK REQUIREMENTS

Upon review by the Admission Advisory Committee (AAC) the following items are required for admission to the transition home:

- Risk Assessment Tool (all)
- Signed Medical Orders
- TB Results and Medical Screening (only for step-down admission, TB results from most recent CTH admission will be sent)
- Behavior Support Plan, if applicable
- Crisis Education and Prevention Plan, if applicable
- SIS
- Relevant ROIs
- Face Sheet, Important Contacts

ATH STAFFING

All staff are cross-trained in the provision of services to individuals diagnosed with DD with co-occurring mental health and/or behavioral challenges.

ATH Treatment/Services

- Behavioral Health Supports
- Vocational Support
- Community Engagement
- Life Skills/Residential Living Skills
- Behavior Support Plans
- Psychotropic Medication Management
- Medical Evaluation and Treatment
- Referrals and Linkages
- Treatment Planning / Discharge Planning

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