FAMILY GUIDANCE CENTER
for behavioral healthcare

EMERGENCY ROOM ENHANCEMENT

REDUCING MULTIPLE, UNNECESSARY HOSPITAL VISITS

SERVICES AVAILABLE

- COMMUNITY RESOURCES
  Case Workers provide access to expedited community resources.
- MEDICAL MANAGEMENT
  We will connect you with access to Physician's Services and monitor /assist with Medical compliance.
- COUNSELING
  We will connect you to Community Mental Health Counseling Services.
- TREATMENT SERVICES
  We will connect you to outpatient Substance Use Services.

WHAT WE DO

Emergency Room Enhancement (ERE) is a collaboration of safety net providers who work to divert persons with psychiatric and substance use disorders from hospitals to alternative services in order to prevent multiple, unnecessary hospital visits. The ERE Team provides timely responses to requests for services including short term intensive response (respite care stabilization intensive case management) and longer term supports promoting self sufficiency (aftercare planning transportation, housing medication management and recovery).

HOW IT WORKS

Hospital staff identifies the patient as appropriate for the program and completes a referral form (on back page). Case managers then connect with the patient to assist with discharge planning, short term crisis intervention services and accessing community services quickly to help the patient stabilize.

ELIGIBILITY

A Missouri resident with 3 or more hospitalizations or ED visits in 90 days or a suicide attempt (including an unintentional overdose) will qualify for services.

Mary Sanders ERE Program Coordinator
816-676-7232

Ashley Evans ERE Care Coordinator
816-261-3913

901 Felix Street, St Joseph, MO 64501
Fax 816.236.2424

EMERGENCY ROOM ENHANCEMENT PATIENT REFERRAL FORM

PLEASE COMPLETE AND FAX THIS PAGE TO 816.236.2424 OR EMAIL FGCERE@FGCNOW.ORG

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ELIGIBILITY

Is this Patient currently a Resident of the State of Missouri? / What County? ______________________

Has Patient Had 3 or More ED Visits or Hospital Admissions in the last 90 Days? ____________

Was the Patient Admitted with a Suicide Attempt or Overdose (Including unintentional)? __________

PATIENT INFORMATION

Referral Date: ____________ Patient Name: ______________________________

Last *First* *M.I.*

SSN: ______________________ DOB: ______________________

Address: ____

Street Address *Apartment/Unit #*

____

City *State* *ZIP Code*

Phone: ______________________ Alt Phone: ______________________

Was Law Enforcement Involved? What County? ______________________________

Primary Physical Concerns (If Applicable): ______________________________

Primary Mental Health Concerns (If Applicable): ______________________________

REFERRING STAFF CONTACT INFORMATION

Your Name/ Department: ______________________________ Phone: ____________________

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