

**AGREEMENT FOR 3 A's of EXCELLENCE  
QUICK ACCESS FACILITY**

I, \_\_\_\_\_, agree to abide by the rules set forth below and any other rules established by 3 A's of Excellence Quick Access Facility.

1. No alcohol or street drugs allowed in the facility. No smoking in the facility. Smoking is only permitted outside in the designated area in the rear of the facility.
2. Quiet hours begin at 10:00 p.m. There should be no loud noises that could possibly disturb the other residents at any time.
3. There will be no solicitation from other residents.
4. I understand that all visitors must be introduced to the staff and are not allowed in the bedrooms. I further understand that there are no visitors allowed after 8:00 p.m.
5. I will not deliberately damage or take any property from this facility. I will pay for any property that I might damage or remove.
6. I agree that I will not threaten or hurt or physically injure myself or anyone else. I understand that violence of any type will not be tolerated.
7. I will notify staff when I leave and give the approximate time of my return.
8. I will return to the facility by 10:00 p.m. unless I have made special arrangements with the staff. If not, I will not be allowed entrance into the facility.
9. I understand that breakfast is available for the residents to prepare and arrangements for lunch and dinner meals will be made by my case manager.

(over)

10. I further understand that I may utilize the laundry facilities that are available in the facility.
11. I will remove all belongings when I leave the facility. If I leave more than two (2) shopping bags of clothing in the facility, I will be charged a \$7.00/day storage fee until I remove all of my belongings. If I have not removed my belongings after thirty (30) days, the facility may dispose of my belongings in any way they see fit.
12. I will actively work with my Community Psychiatric Support Technician (CPST) and/or other mental health workers on developing my housing plan, as noted in #13 below. This may consist of sending referrals to agencies on my behalf, calling landlords and meeting with program or housing intake personnel.
13. I will follow-up on my housing plan and understand that any necessary referrals will be submitted by my CPST within seven (7) working days. My housing plan is as follows:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
14. I understand there is a designated smoking area and agree not to smoke in other areas.
15. I will notify the staff as soon as possible, of the day that I intend to move.
16. I will return all linen, including towels, washcloths, sheets, pillowcases, etc., when I leave.

I authorize the Mental Health Access Point (MHAP) and the Central Community Health Board (CCHB) to share information regarding my stay at the 3 A's of Excellence facility. I further authorize the 3 A's of Excellence Facility to contact my CPST and exchange pertinent information about my stay at the facility.

**"I have read and understand the above stated rules of the 3 A's of Excellence Quick Access Facility. My signature below affirms my agreement to abide by these rules. I further understand that if any of these rules for the 3 A's of Excellence Quick Access Facility are not adhered to, I will be asked to leave."**

\_\_\_\_\_  
 Resident Signature

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Community Psychiatric Support Technician

\_\_\_\_\_  
 Date

**CENTRAL COMMUNITY HEALTH BOARD OF HAMILTON COUNTY, INC.  
RESIDENTIAL SERVICES PROGRAM**

*supported by*

*Hamilton County Community Mental Health Board*

**7162 Reading Road • Cincinnati, Ohio 45237 • 531-0800 • Fax 531-1893**

Bennett J. Cooper, Jr.  
Executive Director

**CLIENT RIGHTS**

I, \_\_\_\_\_, have received and understand OR have had explained, my rights while receiving services from the Central Community Health Board.

Ohio Department of Health \_\_\_\_\_

Ohio Department of Mental Health \_\_\_\_\_

\_\_\_\_\_  
Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness (if unable to read or write)

## Disposition of Personal Belongings

In the event that I leave my belongings at the \_\_\_\_\_  
\_\_\_\_\_ Quick Access facility prior to or after  
my approved discharged date, I hereby give the following  
representative \_\_\_\_\_ my permission  
to remove all my belongings within 24 hours of my departure.

I understand that if my designated representative does not  
remove my belongings within the 24 hour period, my property  
will be disposed of at the discretion of the Quick Access  
facility.

Name: \_\_\_\_\_

Telephone #: \_\_\_\_\_

Address: \_\_\_\_\_

Relationship: \_\_\_\_\_

Signed: \_\_\_\_\_

Date: \_\_\_/\_\_\_/\_\_\_

**AUTHORIZATION FOR DISCLOSURE OF INFORMATION**

**NOTE:** All matters and records relating to the physical or mental condition of clients are privileged and confidential and are treated as such by all clinical staff at this agency. Privileged disclosure of the confidential treatment of present or past patients will not be made without the consent of the client except pursuant to judicial order, in accordance with Public Law 92-255 and Public Law 93-282.

The \_\_\_\_\_ is authorized to release information from my  
(Community Support Provider)

(or give relationship) \_\_\_\_\_. This authorization could include release of  
(Medical Record)

information concerning treatment of drug or alcohol abuse, drug related conditions, alcoholism, psychiatric/psychological conditions, AIDS/AIDS Related Conditions, and/or HIV Testing.

Financial Information, Income.

Verification of any record is also authorized.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Purpose of Disclosure: \_\_\_\_\_

Specific information to be disclosed:

\_\_\_\_\_ Financial Information

\_\_\_\_\_ Income Verification

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During the period from \_\_\_\_\_ to \_\_\_\_\_

This consent to disclose information may be revoked by me at any time except to the extent that action has been taken in reliance thereon.

"In signing this document, I authorize the release of sufficient information to the Mental Health Access Point, the Hamilton County Alcohol and Drug Addiction Services Board and/or the Hamilton County Community Mental Health Board that the Board (s) can enroll me in the Multi-Agency Community Services Information System (MACSIS) and determine my eligibility for publicly funded services."

This consent (unless expressly revoked earlier) expires upon 90 days from this date:

\_\_\_\_\_

\_\_\_\_\_ (specify event or condition after 90 days)

Client signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Case Manager)

**QUICK ACCESS FINANCIAL ARRANGEMENT FORM**

**\*\*\*\* This form must be completed by the client and signed by the client and CPST\*\*\*\***

I understand that my placement in Quick Access Housing is a temporary placement while long term housing arrangements are being made. I understand that my rent is either being subsidized or paid in full by the Central Community Health Board (CCHB), depending on my current financial status.

Accordingly, I understand that Quick Access Housing is not FREE. I agree to the following financial arrangements:

If I have an income, I agree to pay \_\_\_\_\_ (the Lower Amount listed on Line 'C' of the QUICK ACCESS WORKSHEET) per month during my authorized placement at the \_\_\_\_\_ Quick Access Facility.  
Name of Facility

If I have no current income or my income is pending (waiting on determination of entitlements or employment, etc.) I agree to pay a negotiated amount of my income, when it is established, toward the bill for my care. I agree to work with my CPST to determine an appropriate monthly payment plan. This plan will be submitted to the Central Community Health Board (CCHB) Residential Services Program and the agreed upon monthly payment will begin one month after my income starts.

I verify my understanding of these financial arrangements by witness of my signature below. I further understand that failure to comply with the above financial expectations could result in the termination of my placement and/or the denial of authorization for future Quick Access Housing.

\_\_\_\_\_  
Client's Signature and Date

\_\_\_\_\_  
CPST's Signature and Date