

ALEX'S RETREAT "HOUSE RULES"

Listed below are the house rules for this "Quick Access Facility."

1. No alcohol on the premises EVER!!!!!!!!!! Violation of this rule will result in immediate eviction.
2. No drugs of abuse, on the premises EVER. Violation of this rule will result in immediate evection. The exception being prescribes medication from the consumer's physician.
3. This is a "smoke-free" facility; therefore if you smoke, you can utilize the deck in the rear of the house. If inclement weather makes the deck inaccessible, you can smoke in the basement by the garage door. You must receive permission from a staff member or the home administrator prior to going to the basement to smoke.
4. Radio's and televisions can be utilized at the facility, but the operator of such must respect the other clients and keep the sound of both to a minimal
5. Visitors are restricted to the living room area.
6. Clients will NEVER ENTER another client's bedroom without direct permission for the affected client. Violation of this rule will result in immediate evection.
7. All clients will keep their bedrooms cleaned at all times. All responsible for washing any dish or glass that they used.
8. Fighting will not be tolerated. Any arguments or disputes will be immediately brought to the attention of a staff member or the home administrator. Violation of this rule will result in immediate eviction.
9. Check-out time for all consumers will be 10:00am, No Exceptions.
10. Consumers will be required to turn in their bedroom key as well as all linen prior to checking out.
11. All personal property must be removed upon checking out of the facility. Any property that is left at the facility will be stored for a period of Twenty-Four (24) hours. After the twenty-four hours has elapsed, any unclaimed property will be treated as garbage and placed in the trash. There will be a strict adherence to this rule by staff members and the home administrator!

Home Administrator/Staff

Client's Name

Case Manager

Quick Access Payment Worksheet

Please complete this worksheet for all consumers regardless of their income status. Please note that the consumer makes no payments to the facility of placement. If the consumer has an income, monthly payment must be made to:

Central Community Health Board
Attn: Fiscal Department
532 Maxwell Avenue
Cincinnati, Ohio 45219

Checks or money orders should be made payable to the Central Community Health Board and should have the name of the consumer and the Quick Access Facility notes on the check/money order.

Consumers who have no income must make a plan with their CPST's to begin to pay a negotiated amount per month toward the expense of their placement, once their income begins.

_____ X 70% = (A) \$ _____
 Consumer Income Consumer Payment

_____ = (B) \$ _____
 Consumer Placement Location Monthly Cost (see below)

Facility	Cost Per Day	Cost/Month
Tender Mercies/Dana	\$12.50	\$375.00
Anna Louise Inn	\$11.50	\$345.00
3 A's of Excellence	\$16.00	\$480.00
Alex's Retreat	\$16.00	\$480.00
Pro Visions	\$16.00	\$480.00

Select the lower amount of (A) or (B) and put that amount on line (C) to determine the consumer's monthly payment.

Monthly Consumer Payment: \$ _____
 (C)

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

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

Page 2 -- Authorization Disclosure of Information

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)

**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: ____/____/____