

Agreement for Quick Access Housing
Dana Hotel

I, _____, agree to abide by the rules set forth below and by the Dana Hotel.

1. I will not create any loud noises that may disturb other guests/residents at any time.
2. I will not smoke in the non-smoking section.
3. I agree that I will not threaten to hurt or physically injure myself or anyone else. I understand that violence of any type will not be tolerated.
4. I will not deliberately damage or take any property from the hotel. I will pay for any property that I may damage or take.
5. I understand that **illegal drugs, public drinking and/or intoxication** are not permitted on the property of the Dana Hotel.
6. After 5:00 p.m., I understand that I will not have access to the Main Office.
7. I will not use any profanity nor bring any type of weapon into the Dana Hotel.
8. In public areas, I understand that I must be appropriately dressed, i.e. shoes, shirt, pants/dress.
9. I further understand that my guests are not permitted to stay after 9:00 p.m. or overnight.
10. I will work actively with my Community Psychiatric Support Technician (CPST) and/or other mental health workers on developing housing as noted on #12. This may consist of sending referrals to agencies on my behalf, calling landlords and meeting with program or housing intake personnel.

(over)

11. As a Quick Access Resident, if I decide to leave, I will notify the Main Office and I will return the room key.

12. I agree to follow up on my housing plan and understand that any necessary referrals are to be submitted by my CPST within seven (7) working days. My housing plan is as follows: _____

_____.

I authorize Tender Mercies, as operator of the Dana Hotel, the Mental Health Access Point (MHAP) and the Central Community Health Board (CCHB) to share information regarding my stay at the Dana Hotel. I further authorize Tender Mercies to contact my CPST and exchange pertinent information about my stay at the Dana.

“I have read and understand the above stated rules of Quick Access Housing for the Dana Hotel. My signature below affirms my agreement to abide by these rules. I further understand that if any of these rules for Quick Access or for the Dana Hotel are not adhered to, I will be asked to leave.”

Resident Signature

Date

Community Psychiatric Support Technician Signature

Date

I understand that my rent is being subsidized/paid in full (circle one); by CCHB. Accordingly, I agree to the following financial arrangements: _____

_____.

Re-authorization will not be provided without a request. If a re-authorization becomes necessary, I understand that my CPST will need to contact MHAP for approval. If I am eligible to become a permanent tenant, I understand that I will be asked to sign a lease agreement with the Dana Hotel and I/payee will be completely responsible – financially, for my rent at that time.

“I verify my understanding of these financial arrangements by witness of my signature below. I further understand that failure to comply with these financial arrangement will result in the immediate termination of my placement.”

Resident Signature

Clients' Rights Officer or Designee

**TENDER MERCIES INC.
TUBERCULOSIS SCREENING
QUICK ACCESS CLIENTS**

Tender Mercies requires that all individuals entering Dana as part of the Quick Access housing program be screened for tuberculosis. I acknowledge that in order to remain in Quick Access at Dana, I must do the following within the first seven (7) days of admission:

1. Provide Tender Mercies with results of tuberculosis screening (either skin test or chest x-ray) completed within the past ninety (90) days. If I do not have documentation of the test results, I agree to sign a release of information in order for Tender Mercies to obtain the results.

OR

2. Obtain a tuberculosis skin test or chest x-ray and provide Tender Mercies with documentation of the results.

AND

3. If screening results indicate a need for further tuberculosis screening or treatment, in order to remain in Quick Access housing at Tender Mercies it will be necessary to comply immediately with the recommended screening or treatment.

FAILURE TO COMPLY WITH THE ITEMS LISTED ABOVE WILL RESULT IN TERMINATION OF QUICK ACCESS HOUSING AT TENDER MERCIES.

Client Signature

Date

Witness

Date

Name of Case Manager: _____

Agency: _____ Fax #: _____

DEADLINE FOR COMPLETION OF TUBERCULOSIS SCREENING: _____

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
Pye Auburncrest	\$16.00	\$480.00
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

MACSIS RESIDENCY VERIFICATION

The purpose of this form is to clarify which county is responsible for adjudicating claims for behavioral health services provided to the client being enrolled. It should be completed and provided to the enrolling board when:

- The county of the treating facility does not match the legal county of residence of the client as noted on the enrollment form (child or adult, out-of-county).
- The physical address of the client as noted on the enrollment form does not match the legal county of residence of the client (example: domestic violence shelter case, client temporarily living with relatives, child or adult, out-of-county).
- The child's physical address as noted on the enrollment form does not match the legal custodian's address (child only, in or out-of-county).

A client's or legal custodian's signature on this form shall be sufficient for documenting residency with the exception of adults who reside in specialized residential facilities or who are committed pursuant to special forensic categories referenced in the residency guidelines.*

Adult

Client Is an adult? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete the following information.	
Client Name (please print)	
Street Address for Residency Determination Purposes	
City, State, and Zip for Residency Determination Purposes	
Signature of Client	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: ___/___/___

Social Security Administration
Consent for Release of Information

TO: Social Security Administration

Name

Date of Birth

Social Security Number

I authorize the Social Security Administration to release information or records about me to:

NAME

ADDRESS

I want this information released because:

(There may be a charge for releasing information.)

Please release the following information:

- Social Security Number
- Identifying information (includes date and place of birth, parents' names)
- Monthly Social Security benefit amount
- Monthly Supplemental Security Income payment amount
- Information about benefits/payments I received from _____ to _____
- Information about my Medicare claim/coverage from _____ to _____
(specify) _____
- Medical records _____
- Record(s) from my file (specify) _____
- Other (specify) _____

I am the individual to whom the information/record applies or that person's parent (if a minor) or legal guardian. I know that if I make any representation which I know is false to obtain information from Social Security records, I could be punished by a fine or imprisonment or both.

Signature: _____
(Show signatures, names, and addresses of two people if signed by mark.)

Date: _____ Relationship: _____