

*Breezeway on York*  
Silvia Trice, Manager (513) 258-6058

House Rules and Contract Agreement for Quick Access Lodging

***Welcome!***

Upon admission, all items are required to be checked along with an inventory checklist of all items and important documents. This is for the safety of others and a record of your belongings. \_\_\_\_\_

Discharge must occur by 12 noon the day of discharge. Please be prepared to leave the facility at this time. Keys must be returned at this time; you will be charged \$10.00 for lost keys. \_\_\_\_\_

**Continental Breakfast** is served *between* **8:00 a.m. and 9:30 a.m.** in the kitchen area. No food or eating is allowed in the bedroom(s). This refers to storing food as well. \_\_\_\_\_

\*Curfew: Sunday through Thursday: 10:00 p.m.  
Friday & Saturday: 12:00 midnight

**\*This is for your safety and protection**

If you are unable to return to the facility by curfew, please call (513) 258-6058) to gain entrance into the facility and to confirm whereabouts. \_\_\_\_\_

Visitors are welcomed from 2:30 p.m. to 6:30 p.m. on Sunday. Overnight visits are absolutely NOT permitted. Visitors are allowed to have access to the common areas ONLY (sitting area and breezeway) and they must be on the guest list prior to visitation. \_\_\_\_\_

In order to show courtesy/respect for each other, all residents are encouraged to inform others if one will be late returning home and may provide a number where they can be reached. \_\_\_\_\_

I will not create any loud noises or use profanity that may disturb other residents/guests at any time. \_\_\_\_\_

I will smoke in the designated smoking areas only. \_\_\_\_\_

I agree that I will not threaten to hurt or physically injure myself or anyone else. \_\_\_\_\_

I will not deliberately damage or take any property from Breezeway on York and I will be financially responsible for items I unintentionally destroy or remove from the property. \_\_\_\_\_

In public areas, I will dress appropriately, i.e. shoes, shirt, pants etc; \_\_\_\_\_

I will not enter another resident's bedroom or personal space without permission. \_\_\_\_\_

I will not borrow or take any items that are not my belongings without permission and/or approval by the resident or manager.

I will not bring or remove any furniture or household item into or out of the facility. \_\_\_\_\_

All prescribed medications must be safely locked and secured with your personal belongings or facility lock box. \_\_\_\_\_

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*House Rules Continued – Page 2*

I will work actively with my case manager and/or other mental health workers on developing housing options. This may consist of sending referrals to agencies on my behalf, calling landlords and meeting with program of housing intake personnel. \_\_\_\_\_

Laundry must be washed weekly or more frequently if necessary. \_\_\_\_\_

No pets of any kind are permitted. \_\_\_\_\_

No weapons, alcoholic beverages, violence or public intoxication is permitted on the property of Breezeway on York. \_\_\_\_\_

No drugs, illegal drug paraphernalia, loitering and/or solicitation are permitted on the property of Breezeway on York – violating this rule will result in immediate discharge. \_\_\_\_\_.

As a Quick Access Resident, if I decide to leave ahead of schedule, I will notify the manager. \_\_\_\_\_

In an effort to prevent the infestation of bedbugs, I will go to the 1<sup>st</sup> floor and remove all clothing, place worn clothing in plastic bags and secure the bag tightly to be washed the next day. **This procedure must be followed every time you leave and return to the facility.** \_\_\_\_\_

All residents are expected to clean up after themselves and maintain personal grooming. \_\_\_\_\_

All residents are encouraged to participate in fire drills and other safety related procedures. \_\_\_\_\_

Long distance calls are not available and phone usage should be limited to ten (10) minutes per call. In the event there is an emergency, please notify the manager for assistance. \_\_\_\_\_

***\*\*\*Any problems or concerns should be reported to the manager (Silvia Trice) and/or support staff as they arise. \*\*\****

***Remember to be respectful and courteous to others –  
at Breezeway, we treat others how we want to be treated.***

**I, \_\_\_\_\_ agree to abide by the above stated rules set forth by the Breezeway on York facility.**

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

Intake Staff: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Case Manager: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Mental Health Agency: \_\_\_\_\_ Phone: \_\_\_\_ - \_\_\_\_\_

**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 clients 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  
(Community Support Provider or Significant Other)  
\_\_\_\_\_. This authorization could include release of  
(Medical Records)

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 and income.

Verification of any records is also authorized:

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Purpose of Disclosure: \_\_\_\_\_

Specific information to be disclosed:  Financial Information  Income Verification

During the period from \_\_\_\_\_ to \_\_\_\_\_. This consent to disclose  
(Authorization) (End of Authorization)  
information may be revoked by me at any time except to the extent that action has been taken in reliance there on.

“In signing this document, I authorize the release of sufficient information to the Mental Health Access Point (MHAP) and the Hamilton County Mental Health and Recovery Services Board that the Board can enroll me in the Multiagency Community Services Information System (MACSIS) and determine my eligibility for publicly funded services.”

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

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
CPST Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reason for revocation: \_\_\_\_\_  
\_\_\_\_\_

# Client's Rights

I, \_\_\_\_\_ have received and understand or have had explained my rights while receiving services from the Central Community Health Board, Inc. (CCHB)

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

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

\_\_\_\_\_  
Consumer's Signature

\_\_\_\_\_  
Witness Signature (if consumer is unable to read or write)

\_\_\_\_\_  
Date

## Disposition of Personal Belongings

In the event that I leave my belongings at the \_\_\_\_\_ (QA 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:

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

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

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

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

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

Signed: \_\_\_\_\_  
Consumer's Signature

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

## Quick Access Financial Arrangement

*"This form must be read and signed by the consumer 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 following Quick Access Facility: \_\_\_\_\_.

If I have no current income or my income is pending (waiting on determination of entitlement or employment, etc.); I agree to pay a negotiated amount of my income (when it is established) towards 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 CCHB Residential Programs and the agreed upon monthly payment will start one month after my income begins.

I verify my understanding of this financial arrangement 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.

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Consumer's Signature and Date

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CPST's Signature and Date

# Quick Access Payment Worksheet

Updated 2/8/10 uje

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, payment(s) must be made to:

Central Community Health Board, Inc.

Attn: Ursula J. Epps

526 Maxwell Avenue

Cincinnati, Ohio 45219

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

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

\_\_\_\_\_ x 70% = (A) \_\_\_\_\_  
Consumer's Income Consumer's Payment

\_\_\_\_\_ = (B) \_\_\_\_\_  
Consumer's Placement (i.e. Alex's, Dana...) Monthly Cost (See Below)

Facility	Daily Cost	Monthly Cost
Tender Mercies/Dana	\$12.50	\$375.00
3 A's of Excellence	\$16.00	\$480.00
Alex's Retreat	\$16.00	\$480.00
Serenity	\$16.00	\$480.00

(C) Monthly Consumer Payment: \$ \_\_\_\_\_.