

Dana Hotel
Agreement for Quick Access Housing

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 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 and/or 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 case manager and/or mental health workers on developing housing. This may consist of sending referrals to agencies on my behalf, calling landlords and meeting with program or housing intake personnel.
- 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 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 case manager and exchange pertinent information about my stay at the Dana Hotel.

I understand that my rent is being subsidized/paid in full (circle one); by CCHB. Accordingly, if I have an income, I will either repay the debt in full or make payment arrangements. Re-Authorization will not be provided without a request. If a re-authorization becomes necessary, I understand that my case manager 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 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 verify my understanding of the above stated financial arrangements. 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

Case Manager or Designee Signature

____/____/____
Date

Tender Mercies Inc.
Tuberculosis Screening for Quick Access Consumers

Tender Mercies requires that all individuals entering the Dana as part of the Quick Access housing program be screened for tuberculosis. "I acknowledge that in order to remain in Quick Access at the 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 sing a release of information in order for Tender Mercies to obtain the results.

OR

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

OR

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.

Resident Signature

____/____/____
Date

Witness Signature

____/____/____
Date

Case Managers' Name: _____

Agency: _____

Fax #: _____ - _____

Deadline for completion of tuberculosis screening: ____/____/____

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.

Consumer's Signature and Date

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.

$$\frac{\text{Consumer's Income}}{\text{Consumer's Income}} \times 70\% = (A) \quad \frac{\text{Consumer's Payment}}{\text{Consumer's Payment}}$$

$$\frac{\text{Consumer's Placement (i.e. Alex's, Dana...)}}{\text{Consumer's Placement (i.e. Alex's, Dana...)}} = (B) \quad \frac{\text{Monthly Cost (See Below)}}{\text{Monthly Cost (See Below)}}$$

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: \$ _____.