

## *Sycamore Hotel Payment Voucher*

1). *This voucher authorizes payment from the Central Community Health Board for accommodation at:*

*Site:* Sycamore Hotel

*Address:* 7759 Reading Road, Cincinnati, Oh. 45237

*Consumer:* \_\_\_\_\_

2). *Move In Date:*     /    /    

*Move Out Date:*     /    /    

*Rate:* \$150.00 per week

3). *The Central Community Health Board will be responsible for payment ONLY for the authorized number of nights indicated in #2 above.*

4). *The Central Community Health Board is responsible only for payment for accommodation. **The room/accommodation should be registered in the “voucher holding client’s name.”** The “voucher holding client” will assume ALL liability except for payment for the above stated authorized number of nights. Note: This voucher is payment for a ROOM ONLY.*

5). *Authorization provided by Sandra Driggins-Smith of the Central Community Health Board of Hamilton County, Inc. on     /    /    .*

\_\_\_\_\_  
*Sandra Driggins-Smith or Designee’  
Central Community Health Board, Inc.*

    /    /      
*Date*

*I have read the above voucher and agree with it’s terms.*

\_\_\_\_\_  
*Voucher Holding Client*

    /    /      
*Date*

\_\_\_\_\_  
*Case Manager*

    /    /      
*Date*

*Case Management Agency:* \_\_\_\_\_

*Emergency #:* \_\_\_\_\_

## 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: \$\_\_\_\_.\_\_\_\_

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

\_\_\_\_\_

## 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: \_\_\_/\_\_\_/\_\_\_

# 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

