

HOPEWELL FINANCIAL APPLICATION

Name of Resident: _____ Resident Social Security Number: _____

The following information is being asked to assist in determining financial assistance. If you wish us to consider retirement accounts in the calculation, please list them under other.

Determination will not be made without a copy of the first two pages of your most recent Federal Income Tax form attached.

	Responsible Party #1	Responsible Party #2	Number in Household
Name:			Adults:
Street Address:			Children:
City, State Zip			
Home Phone:			
Cell Phone:			
Email Address:			
Social Security #:			
Birth Date:			
Tax Filing Status:			
Annual income from work:			
Annual SSI/SSDI Income:			
Annual Income from other sources:			

Assets:	Total Amount	Liabilities:	Total Amount
Residence (market value)		Residence	
Other real estate (market value)		Other real estate	
Business / Farm assets		Business / Farm liabilities	
Checking		Credit Cards	
Savings		Car Loans	
Stocks/Bonds/Investments (not retirement accounts)		Student Loans	
Trust Funds		Other _____	
Other _____		Other _____	
Other _____			

Any pertinent information not covered:

I authorize Hopewell to verify the information provided on this form and to obtain my credit history.

Responsible Party #1 _____ Date _____
Signature

Responsible Party #2 _____ Date _____
Signature



a therapeutic farm community

9637 State Route 534
Middlefield, OH 44062
P. 440-426-2000 F. 440-426-2002
www.hopewellcommunity.org

Please fill out this form in its entirety. Attach a copy of both front and back of each insurance card. This form and card copies must accompany the completed Financial Application for Admission purposes for Hopewell.

Primary Health Insurance

Resident's Name: _____ DOB: _____

Subscriber's Name: _____ DOB: _____ SS#: _____

Name of Insurance Company: _____

(Medical) Subscriber's ID # : _____ Group #: _____

Subscriber's Address: _____

Subscriber's Employer: _____

A quote of benefits and /or authorization does not guarantee payment or verify eligibility. Payments of benefits are subject to all terms, conditions, limitations, and exclusions of the member's contract at the time of service. Once approved, your insurance company may choose to no longer cover the Resident's care because they do not deem a residential level of care medically necessary. At that point you will be given a choice for the Resident to be referred to an in-network outpatient provider, or to stay at Hopewell. Should the Resident decide to stay at Hopewell, you will be responsible for all fees. The existence of availability of insurance or governmental agency monies, does not replace or relieve the Responsible Party of his or her joint and several obligations under the Admission Agreement for the payment of fees.

Vision Insurance

Subscriber's Name: _____ DOB: _____ SS#: _____

Name of Insurance Company: _____

(Vision) Subscriber's ID # : _____ Group #: _____

Dental Insurance

Subscriber's Name: _____ DOB: _____ SS#: _____

Name of Insurance Company: _____

(Dental) Subscriber's ID # : _____ Group #: _____

Pharmacy Insurance

RxBIN: _____ RxPCN: _____

RxGRP: _____ (If there is a secondary insurance please send copies as well.) **Please indicate if there is a specific location/pharmacy your insurance company requires you to have prescriptions filled.** _____

PSYCHIATRIC REFERRAL FORM

Please have this form completed in its entirety by client's psychiatrist, or any independently licensed mental health professional. If the individual is on medications, the prescribing professional must sign off on the current medication regimen.

Date: ___/___/___

Name of client referral: _____ Length of treatment _____

Psychiatrist's Name: _____

Office Address:

_____ Street _____ City _____ Zip code _____

Ph #: _____ Fax #: _____

Email _____

D.O.B.: ___/___/___ SSN: ___/___/_____

Guardian: YES NO

If YES, list name and attach a copy of guardianship papers: _____

DIAGNOSIS: *Hopewell is a Therapeutic Farm Community specializing in Mental Health Treatment. Our Admission Criteria is structured to meet a Residential Mental Health Treatment (RTC) level of care.*

Please complete the DSM-V or DSM-IV-TR code and current diagnoses for the referred client:
CODE DIAGNOSIS

_____/_____
 _____/_____
 _____/_____
 _____/_____
 _____/_____

If available please include current GAF Score: _____

Past Diagnoses include:

Length of stay recommended: ___3-6 months ___6-12 months ___ long term treatment

CURRENT MENTAL STATUS:

YES NO Suicidal History
Ideation Dates: _____, _____, _____, _____ method _____
Plan Dates: _____, _____, _____, _____ method _____
Attempt Dates: _____, _____, _____, _____ method _____

YES NO Aggression History
_____ Verbal Who _____ when _____
_____ Physical Who _____ when _____
_____ Assault History Dates: _____, _____ method _____

YES NO Arrest Record
Dates: _____ reason _____
Current Status _____ Probation/Parole _____
Dates: _____ reason _____
Current Status _____ Probation/Parole _____

YES NO Sexual Abuse Victim / Perpetrator
YES NO Physical Abuse Victim / Perpetrator
YES NO Substance Abuse
Type:
____ Cigarettes
____ Caffeine
____ Medication
____ Alcohol
____ Illegal (list) _____
____ Other _____

YES NO Recent trauma
YES NO Homeless
YES NO Family Support
YES NO Delusions
Type:
____ Grandiose
____ Somatic
____ Religious
____ Other _____

YES NO Hallucinations
Type:
____ Auditory
____ Visual
____ Other _____

YES NO Self Abuse

YES NO Appropriate Affect
Type:
____ Animated
____ Blunted
____ Flat
____ Inappropriate
____ labile
____ Constricted

____ Other _____

YES NO Client has Judgment/ Insight relating to safety of self/others; to include children and animals

YES NO Independent Living Skills

____ Regular staff support for daily prompting

____ 1:1 staff support

Please add additional comments

Current Psychiatric Prescribed MEDICATIONS:

Please write-in below or attach a current medication record

MEDICATION	DOSE	FREQUENCY	RATIONALE
_____ / _____ / _____ / _____			
_____ / _____ / _____ / _____			
_____ / _____ / _____ / _____			

Frequency of monitoring if client is prescribed Clozapine: Weekly Biweekly Monthly

PRN MEDICATION	DOSE	FREQUENCY	RATIONALE
_____ / _____ / _____ / _____			
_____ / _____ / _____ / _____			

- Provide a recent copy of drug levels for applicable medications (i.e. Lithium, Depakote, Tegretrol, Lamictal, Clozapine) and a copy of all recent lab work and drug screens. If client has a known history of substance abuse, a drug screen that has been taken within 30 days of admission is required.
- All clients **MUST** arrive with a 30 day supply of medications.

PSYCHIATRIST SIGNATURE: _____

PSYCHIATRIST NAME (PRINTED): _____

DATE: _____

Other Licensed individual completing this form: _____

Signature Date

Printed Name: _____

Please add additional comments:

Hopewell History and Physical

Hopewell is a residential farm community for adults with chronic mental illness. This form is to be completed as an initial part of the admission assessment process and annually thereafter. Candidates need to demonstrate a level of health that allows for physical work on a farm and ability to safely navigate between buildings over uneven ground.

The Hopewell History and Physical is to be completed by the potential resident's primary care provider or hospital generalist within thirty days of admission.

Client Name: _____

Date of Exam: _____

Date of Birth: _____ Age: _____ Gender: F M T

Home Address: _____

City: _____ State: _____ Zip Code: _____

E-Mail: _____ Preferred Phone # _____

Medical History

Family History: Please identify biologically related family members who have had any of the following conditions:

Disease Type	Family Members Diagnosed	Deceased? Yes or No
Cancer (specify type)		
Bleeding Disorder		
Diabetes		
Genetic Disorder		
Cardiovascular Diseases		
Pulmonary Diseases		

Client Allergies:	List Allergies	List Reactions
Medication Allergies		
Food/Environmental Allergies		

Medications and Supplements:

Please list ALL medications including routine, as needed meds, nutritional supplements, herbs, vitamins and over the counter meds OR check here if medication list/MAR is attached.

Standing Medications:

Name	Dose	Time	Reason	Prescriber

Current Medical Diagnoses/Significant Health Conditions/Significant Surgeries:

Name: _____ Date of Birth: _____ Page

REVIEW OF MEDICAL SYSTEMS

System Name	Normal Findings?	Comments/Description
Integumentary	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Neurologic	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Respiratory/Nose/Mouth/Throat/Lungs	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Endocrine	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Cardiovascular	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Gastrointestinal	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Special Diet	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Genitourinary	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Hematologic	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Musculoskeletal	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Reproductive	<input type="checkbox"/> Yes <input type="checkbox"/> No	
For Women- Last mammogram?	Date: _____	
For Women-Last menstrual period?	Date: _____	
Lymphatic	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Eyes/Ears/Head/Face/Neck	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Vision and Hearing	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Height _____ Weight _____ Blood Pressure _____ Pulse _____ Respirations _____ Temp _____

Is further evaluation recommended by a specialist in any of these areas Yes No

Please explain: _____

Last dental appointment: _____ Dentist: _____

Last vision exam: _____ Doctor: _____

Is client at risk for TB? YES NO

If YES, please complete a 2 Step TB Test, TB blood test or Chest X-ray

2 Step TB Test Dates: Step 1: _____ Step 2: _____ Results: Step1: _____ Step 2: _____

Blood test/Chest X-ray date: _____ Results: _____ (attach copy of lab report)

Is client up to date on age- appropriate vaccines? Yes No

Date of last tetanus: _____

Date of last Covid vaccine: _____

Is this client free of any communicable disease Yes No If no, please explain _____

****Please provide copies of recent (within past year) lab work including TFT, liver and renal function tests, CBC, lipid profile, drug level monitoring, & drug screens****

Healthcare Provider name (PA, MD, DO or NP): _____ Title _____

Healthcare Provider Signature _____ Date _____

Name: _____ Date of Birth: _____ Page _____

Nursing Department Services at Hopewell

Hopewell employs RNs and LPNs to staff the nursing department. In addition, a consulting psychiatrist works closely with Hopewell staff and is on site approximately once per week. This is a brief overview of the psychiatric, medical, and nursing services which may be provided by the nursing department on behalf of residents and their families.

- Nurses collaborate with each resident at least once a week to prepare a weekly medication sleeve and provide medication education.
- Nursing and program staff assist residents with the self-administration of medication using this med sleeve.
- Medication management, including liaison with our preferred pharmacy vendor to avoid interruption of services. Families may use other pharmacies if necessary. Please call nursing to discuss.
- Nursing coordinates annual health physicals for each resident.
- Monthly vital signs including weight are monitored, unless ordered more frequently.
- Over the counter medications are provided as necessary and are ordered by a physician.
- Nursing coordinates scheduling for all other medically-related health care needs that arise (e.g., dental, vision, gynecology, etc.)
- ALL staff are CPR/First Aid certified and can provide minor emergency first aid. Community Care ambulance can be called to transport a non-life threatening injury/ illness to a local emergency room if further assessment is needed.
- Major medical and psychiatric emergencies are transported by ambulance (911) to the nearest hospital (Geauga Medical Center.)
- The consulting psychiatrist meets with residents approximately once a month or as scheduled. The psychiatrist works closely with the clinical team and participates in treatment planning. Medication or treatment changes may occur on a day when the resident is not scheduled to see the psychiatrist face to face.
- Residents may continue to have care coordinated through their individual psychiatrists as desired and if possible. Veterans generally continue to meet with their VA psychiatrist. In both cases, nursing staff will coordinate care and collaborate with the psychiatrist involved.
- Transportation to all medical and psychiatric appointments can be provided by Hopewell (please note there is a fee for some transports.) Please contact the nursing department for more details.
- Nurses are present on campus Monday through Friday during daytime hours, although one member of the nursing staff is always available by phone.
- To contact nursing please dial the main number for Hopewell and ask the operator to page the nurse.

Family and Personal History

Name of the potential resident (**PR**) being referred to Hopewell: _____

Age: ____ DOB: ____/____/____ SS#: ____/____/____ Address: _____

Phone: ____ - ____ - ____ County of residence: _____

Current living situation: _____

Person providing information: Name: _____ Relationship: _____

Address: _____

Home Phone # _____ Cell # _____

Names and relationships of significant family and/or other for emergency contact purposes:

Name: _____ Address: _____ Relationship: _____

Home Phone # ____ - ____ - ____ Cell # ____ - ____ - ____ Email: _____

Name: _____ Address: _____ Relationship: _____

Home Phone # ____ - ____ - ____ Cell # ____ - ____ - ____ Email: _____

History of behaviors that illustrate the family's concerns or reasons for the referral:

When did the family first begin to notice behaviors that may be related to mental illness?

Were there any significant and/or traumatic events in the lives of your family members? (Please describe)

Are there any legal issues regarding the PR? Yes No (If yes please describe)

Does the PR have any medical problems? Yes No

(If yes please describe)

Has the PR ever suffered a head injury? Yes No

(If yes please describe)

Is there history of mental illness and/or alcohol & drug use in the family? Yes No

Relationship to PR: _____ Diagnosis: _____

Relationship to PR: _____ Diagnosis: _____

Is there any history of drug or alcohol abuse with the PR? Yes No

Date of last use: _____ Substances Abused: _____

Has the PR ever been hospitalized? Yes No (If yes please provide name(s) of hospital(s))

Hospital: _____ Approximate dates: _____

Hospital: _____ Approximate dates: _____

Hospital: _____ Approximate dates: _____

Hospital: _____ Approximate dates: _____

Is the PR currently being provided case management through a mental health agency? Yes No

Name of agency: _____ Case Manager: _____ Ph. # _____

Please describe the PR's strengths _____

Please describe any limitations the PR may have with regard to daily living skills, i.e., self-care, bathing, dressing, cleanliness, vocational skills, social skills: _____

Sexual History/Concerns of the PR: _____

Identify if there is a history of any of the following: Please explain any [X] areas

[] Physical Abuse: _____

[] Mental Abuse: _____

[] Sexual Abuse: _____

[] Emotional Abuse: _____

[] Domestic Violence: _____

[] Community Violence: _____

[] Physical Neglect: _____

[] Elder Abuse: _____

[] Cruelty to Animals: _____

Does the PR have a legal guardian? [] Yes [] No If so, guardian of: [] Person [] Estate [] Both

Please provide name/ address/ phone # along with proper documentation of guardianship

Are there other areas that are important for the staff to understand about the person who may live at Hopewell?

Did PR ever serve in the military? [] Yes [] No

Does PR receive VA benefits? [] Yes [] No Amount per month \$ _____

Is the PR currently receiving Social Security benefits? [] Yes [] No monthly amount: \$ _____

Is there a payee for their Social Security? [] Yes [] No

Please provide name/address/phone # _____

Is the PR currently receiving Medicare? [] Yes [] No Please provide Medicare # _____

Is the PR currently receiving Medicaid? [] Yes [] No Please provide Medicaid # _____

Does the PR have private insurance? [] Yes [] No Insurance Company _____

ID# _____ Group # _____ Phone # _____

Does PR have Prescription Coverage? [] Yes [] No Insurance Co. _____

If yes, please include following information from Ins. Card: RxBIN: _____ RxPCN: _____ RxGRP: _____

Hopewell will assist residents in applying for or maintaining Social Security and Medicaid benefits.

Copies of front and back of the following items must be submitted upon admission:

Birth Certificate

Social Security Card

Private Insurance Card, Medicare Card, Medicaid Card

Current Photo ID

To what extent does the family or PR consider spirituality or religion important to their lives?

Are there any significant cultural or ethnic issues? _____

Please provide a history of the educational experiences for the PR: _____

Please provide a history of the vocational or work experiences for the PR: _____

Identify any problems in the following areas: Please explain any [X] areas

Nutrition/Eating patterns, changes, disorders: _____

Pain Management: _____

Depressed Mood/Sad: _____

Anxiety: _____

Traumatic Stress: _____

Anger Aggression: _____

Oppositional Behaviors: _____

Inattention/Withdrawal: _____

Impulsivity: _____

Disturbed Reality Contact (psychosis): _____

Bizarre Thoughts: _____

Mood Swings/Hyperactivity: _____

Sleep Problems: _____

Social Stressors: _____

Current risk to self or others: _____

History of harming self or others: _____

Authorization for Release of Confidential Information

FROM THE RECORDS OF:

Client Name _____ **Date of Birth** _____
 (Please Print) Last First M/I

This release authorizes: Hopewell staff to: [] receive from, [] disclose to:

 (Name of Organization/Person & Relationship) City State Zip Code

Phone # _____ **Fax #** _____

Please provide information in the format checked: [] Verbal [] Written [] Verbal and/or Written

Description of Information to be released:

- | | | |
|---|---|---|
| <input type="checkbox"/> Diagnostic Assessment & Update | <input type="checkbox"/> Treatment Plans | <input type="checkbox"/> Information Shared During Staffing |
| <input type="checkbox"/> Psychiatric Examinations | <input type="checkbox"/> Orders | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Psychological Evaluations | <input type="checkbox"/> Consultations | <input type="checkbox"/> Lab Results |
| <input type="checkbox"/> Nursing Assessment | <input type="checkbox"/> Quarterly Report | <input type="checkbox"/> Discharge Summaries |
| <input type="checkbox"/> Health History & Physical | <input type="checkbox"/> Drug Screens/Treatment | <input type="checkbox"/> Other (specify) _____ |

Purpose of disclosure is to: [] Assess for Possible Admission [] Continuity of Care [] Updates on Progress [] Other _____

I understand that I, and/or my guardian, if appropriate, may shorten or lengthen the authorization period or may revoke this authorization at any time, except to the extent that action has been taken in reliance on it. If not previously shortened, lengthened or revoked, this authorization is valid for the duration of treatment and residence at Hopewell.

I understand that the information disclosed is protected by law and may not be re-disclosed without my written authorization or as otherwise authorized by law; however, I understand that Hopewell cannot control the recipient's use of the information.

I understand that my treatment, payment for my services, my enrollment or eligibility for benefits cannot be conditioned upon my giving authorization for disclosure of information.

I expressly consent to the release of information designated above. I understand and acknowledge that this authorization extends to all or any part of the records designated above, which may include treatment for mental illness (ORC5122.31), alcohol/drug use and/or abuse (42 CFR Part 2), and/or Human Immunodeficiency Virus (HIV)/acquired Immune Deficiency Syndrome (AIDS) test results or diagnosis (ORC3701.24.3). I understand that the information disclosed is protected by law and may not be re-disclosed without my written consent or as otherwise authorized by law; however I understand that Hopewell cannot control the recipient's use of the information. Records obtained from other sources and made available to Hopewell may not be re-disclosed to other parties.

Signature of Individual _____
Date

Signature of Guardian/Personal Representative _____
Date

Relationship to Patient/Resident _____
Date

Signature of Hopewell staff facilitating disclosure of information _____
Date

TO BE SIGNED ONLY IF AUTHORIZATION IS REVOKED

This authorization can be revoked at any time by providing written notice to Hopewell. I understand that any information released prior to revocation cannot be retrieved and that Hopewell will not be held responsible for such. I hereby release Hopewell from all legal responsibilities or liability that may arise from this act.

SIGNATURE OF INDIVIDUAL/GUARDIAN: _____ DATE: _____

WITNESS: _____ TIME: _____ DATE: _____

Resident Name _____ **PIN N/A Date** _____

Strengths/Resources

Needs

What are some things that help you? Check all that apply and list others you think will help.

- 1. Support from family (parents, children, others)
- 2. Support from spouse or significant other
- 3. Connection to self-help group (AA, NAMI, etc.)
- 4. A positive and supportive sponsor
- 5. Connection to a church group or minister
- 6. Access to a spiritual practice group
- 7. Counselor or case manager who helped you get into treatment
- 8. Someone who helped you get into Hopewell
- 9. Financial assistance or benefits coming to me
- 10. Permanent residence/housing option
- 11. Work/ vocational options/connections at discharge
- 12. Work/ vocational experience doing _____
- 13. Connections to volunteering I have done
- 14. Connection to a community _____
- 15. Connections to a mental health facility and/or psychiatric care; provisions for obtaining medications
- 16. Supportive friends
- 17. Community involvement _____
- 18. A guardian who is helpful
- 19. Recreation/leisure connections
- 20. Driver's license
- 21. Others: _____
- _____
- _____
- _____

What do you want to learn while at Hopewell? Check all that apply and list other things you can think of that are not shown.

- 1. Education about mental disorders
- 2. Education about substance abuse
- 3. An explanation of my diagnosis
- 4. Improvement in my communication skills
- 5. Improvement in my interpersonal skills
- 6. Contact with supportive others
- 7. Emotion-management skills
- 8. Anger-management skills
- 9. A personal safety plan
- 10. Medication education
- 11. Getting and keeping a job
- 12. Education about improving my health
- 13. Relapse prevention or recovery plan
- 14. Coping with symptoms, e.g., voices, confusion
 Specific symptoms _____
- 15. Relapse prevention skills
- 16. Art & creative expression class
- 17. Money management skills, e.g., checking
- 18. Independent living skills, e.g., cooking
- 19. Assistance with housing
- 20. Empowerment/advocacy training
- 21. Benefit analysis for SSI/SSDI and work
- 22. Understanding of how Hopewell works for me
- 23. Exercise opportunities & guidance
- 24. ADL assistance, e.g., grooming hygiene
- 25. Managing sleep schedule
- 26. Help dealing with groups and many people
- 27. Support to manage limitations in _____
- 28. Others: _____
- _____
- _____
- _____

This form is to be completed by each resident during their initial assessment at Hopewell. Residents may request and receive assistance from their clinical manager, prime staff or others.

Person Assisting (if requested) _____ **Date** _____

Resident Name _____ PIN <u>N/A</u> Date _____	
Abilities	Preferences/Expectations
<p>What are some of your personal qualities, skills or talents that will help you in recovery? Check all that apply and list others you think will help.</p> <ul style="list-style-type: none"> <input type="checkbox"/> 1. I am very motivated for treatment <input type="checkbox"/> 2. I am able to make an appropriate transition to living in a recovering community <input type="checkbox"/> 3. I have good interpersonal/communication skills <input type="checkbox"/> 4. I have good emotion-management skills <input type="checkbox"/> 5. In the past I have demonstrated openness and honesty with regard to my recovery <input type="checkbox"/> 6. I have been able to let go of the denial that I once had about my mental disorder <input type="checkbox"/> 7. I have been able to let go of the denial that I once had about my substance abuse <input type="checkbox"/> 8. I have some insight into my substance abuse and mental disorder <input type="checkbox"/> 9. I have good self-esteem <input type="checkbox"/> 10. I have some positive plans and goals for my future <input type="checkbox"/> 11. I am willing to do what it takes to be in recovery <input type="checkbox"/> 12. I have good work skills doing _____ <input type="checkbox"/> 13. I'm aware of how work effects benefits <input type="checkbox"/> 14. I'm aware of supports/resources in my community <input type="checkbox"/> 15. I have a good relationship with a higher power <input type="checkbox"/> 16. In spite of past hardships, there are still areas of my life in which I take pleasure <input type="checkbox"/> 17. I am a helpful caring person, capable of offering support to others in recovery <input type="checkbox"/> 18. Able to function in groups <input type="checkbox"/> 19. Good grooming hygiene & self-care <input type="checkbox"/> 20. I'm generally physically fit <input type="checkbox"/> 21. Good spiritual practice, e.g., prayer, yoga <input type="checkbox"/> 22. I can teach or offer my experience in _____ <input type="checkbox"/> 23. I have already overcome obstacles in my life <input type="checkbox"/> 24. Special talents _____ <input type="checkbox"/> 25. I am knowledgeable in _____ <input type="checkbox"/> 26. Others: _____ 	<p>What do you hope to get out of Hopewell? Check all that apply and list other things you can think of that are not shown.</p> <ul style="list-style-type: none"> <input type="checkbox"/> 1. I will learn the skills to stay mentally stable <input type="checkbox"/> 2. I will learn the skills to stay clean and sober <input type="checkbox"/> 3. I will have a better understanding of my diagnosis <input type="checkbox"/> 4. I will be able to communicate more effectively <input type="checkbox"/> 5. My interpersonal skills/relationships will improve <input type="checkbox"/> 6. I will develop a system of support in recovery <input type="checkbox"/> 7. I will be able to better manage my emotions <input type="checkbox"/> 8. I will be able to better manage my anger <input type="checkbox"/> 9. My health will improve __ physically__ mentally <input type="checkbox"/> 10. I will have a better understanding of relapse prevention <input type="checkbox"/> 11. I will have an illness management plan <input type="checkbox"/> 12. I will learn how to reunite with my family <input type="checkbox"/> 13. I will learn to get a job <input type="checkbox"/> 14. I will learn ways to live well & be happy <input type="checkbox"/> 15. Personal safety plan preferences <ul style="list-style-type: none"> PRN meds _____ Physical restraint _____ Open quiet room _____ <input type="checkbox"/> 16. I will learn self-advocacy & empowerment <input type="checkbox"/> 17. I will learn how to engage in activities I enjoy <input type="checkbox"/> 18. I prefer to work in <ul style="list-style-type: none"> Large Groups _____ Small Groups _____ Individually _____ <input type="checkbox"/> 19. Exercise in class, with equipment, inside or outside <input type="checkbox"/> 20. Spiritual/religious preference _____ <input type="checkbox"/> 21. Less help will be needed from case managers & staff <input type="checkbox"/> 22. I will stay out of the hospital <input type="checkbox"/> 23. I will take my medication as prescribed <input type="checkbox"/> 24. I will use coping skills instead of self-harming <input type="checkbox"/> 25. Others: _____