HOPEWELL FINANCIAL APPLICATION

Name of Resident:_____________________________________ Resident Social Security Number: ________________

The following information is being asked to assist in determining financial assistance.

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**
Name:		
Street Address:		
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:		

Number in Household
Adults:
Children:

Assets:	Total Amount
Residence (market value) ……………..……..	
Other real estate (market value) ……..……...	
Business / Farm assets ………………………	
Checking……………………………………	
Savings ……………………………………..	
Stocks/Bonds/Investments ………………..…	
Trust Funds ………...………………………..	
Other ________________________________	
Other ________________________________	

Liabilities:	Total Amount
Residence …………………...………………..	
Other real estate ………………...………...	
Business / Farm liabilities ……………………	
Credit Cards …………………………………	
Car Loans ……………………………………	
Student Loans …...……………………………	
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

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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.** ____

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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:

____

____

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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.

Please have this form completed in its entirety by the resident's primary care provider or hospital generalist within 30 days of admission.

Physician Information:

Physician's Name: ____________________

Office Address: ____________________

City: ____________________ State: __________ Zip Code: ____________

Ph #: ____________________ Fax #: ____________________

Email ____________________

Client Information:

Last name: ____________________ MI: ____ First Name: ____________________

Date of Birth: ____________ Age: ________ Gender: F M T

Home Address: ____________________

City: ____________________ State: __________ Zip Code: ____________

E-Mail:____________________

Home #____________Work #____________ Cell#____________

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
Osteoporosis		
Cancer (specify type)		
Bleeding Disorder		
Diabetes		
Genetic Disorder		
Cardiovascular Diseases		
Pulmonary Diseases		

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

Medications and Supplements:

Please list ALL medications including as necessary meds, nutritional supplements, herbs, vitamins and over the counter meds (use back of sheet if necessary):

Standing Medications:

Name	Dose	Time	Reason	Prescriber

REVIEW OF MEDICAL SYSTEMS

❍Check this sleeve if previously had and provide dates if known in comment section
☐Check this sleeve if currently has

Integumentary
❍☐ Skin rashes ❍☐ Psoriasis ❍☐ Skin cancer ❍☐ Piercings ❍☐ Scars
❍☐ Slow healing ❍☐Herpes ❍☐ Discolorations ❍☐ Changes in moles ❍☐ Bruise easily
❍☐ Pruritis ❍☐ Sores ❍☐ Tattoos
Comments: ____

Neurological
❍☐ Syncope ❍☐ Disorientation ❍☐ Weakness ❍☐ Confusion
❍☐ Memory Loss ❍☐ Concussion ❍☐ Loss of coordination ❍☐ Numbness
❍☐ Difficulty speaking ❍☐ Headaches ❍☐ Difficulty walking ❍☐ Tingling
❍☐ Multiple Sclerosis ❍☐ Migraines ❍☐ Stroke ❍☐ Tremors
❍☐ Parkinson's Disease ❍☐ Epilepsy ❍☐ Dementia ❍☐ Cerebral palsy
❍☐ Dizziness ❍☐ Seizures ❍☐ Head Injury
Comments: ____

Sensory
❍☐ Glaucoma ❍☐ Ear pain ❍☐ Cataracts ❍☐ Dental problems
❍☐ Blurred vision ❍☐ Hearing loss ❍☐ Double vision ❍☐ Ear noises
❍☐ Glasses ❍☐ Contacts ❍☐ Dentures ❍☐ Hearing Aide
❍☐ Loss of smell

Last dental appointment: ______________ Dentist: _________________________________
Last vision exam: ____________________ Doctor: _________________________________
Comments: ____

Respiratory
❍☐ Nose bleeds ❍☐ Hoarseness ❍☐ Sore throats
❍☐ Coughing ❍☐ Pneumonia ❍☐ Bronchitis ❍☐ Sinusitis
❍☐ Hematamesis ❍☐ Difficulty breathing ❍☐ Emphysema ❍☐ SOB
❍☐ Asthma ❍☐ Tuberculosis ❍☐ Lung cancer

Is client at risk for TB? (See page 4): 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)
Comments: ____

Endocrine
❍☐ Hypothyroidism ❍☐ Hyperthyroidism ❍☐ Diabetes ❍☐ Goiter
Comments: ____

Cardiovascular
❍☐ Hypertension ❍☐ Aneurysm ❍☐ Chest pain
❍☐ Heart attack ❍☐ Hypotension ❍☐ Edema
❍☐ Irregular heartbeat ❍☐ Cardiomegaly ❍☐ High triglycerides
❍☐ Murmurs ❍☐ High cholesterol levels ❍☐ Rheumatic fever
Comments: ____

Name: ____ Date of Birth: _______________________

Gastrointestinal

❍☐ Cholecystitis ❍☐ Constipation ❍☐ GERD ❍☐ Encopresis
❍☐ Liver trouble ❍☐ Diarrhea ❍☐ Colostomy ❍☐ Hematemesis
❍☐ Hepatitis ❍☐ Ulcers ❍☐ Hiatal hernia ❍☐ Pancreatitis
❍☐ Heartburn ❍☐ Colitis ❍☐ Colon cancer ❍☐ Melena/Hematochezia
❍☐ Weight loss ❍☐ Weight gain ❍☐ Loss of appetite ❍☐ Vomiting
❍☐ Swallowing problems

Diet: ____

Comments: ____

Genitourinary

❍☐ Painful urination ❍☐ Frequent urination ❍☐ Kidney infection ❍☐ Kidney stones
❍☐ Hematuria ❍☐ Incontinence ❍☐ Urostomy

Comments: ____

Hematologic

❍☐ Anemia ❍☐ Bleeding disorder ❍☐ Sickle cell anemia ❍☐ Lymphoma
❍☐ Clotting issues ❍☐ History of clots

Comments: ____

Musculoskeletal

❍☐ Arthritis ❍☐ Head injury ❍☐ Fibromyalgia
❍☐ Osteoarthritis ❍☐ Neck injury ❍☐ Muscle weakness ❍☐ Gout
❍☐ Rheumatoid arthritis ❍☐ Back injury ❍☐ Osteoporosis ❍☐ Scoliosis
❍☐ Spinal trauma ❍☐ Muscular dystrophy ❍☐ Lupus
❍☐ Birth trauma ❍☐ Spina bifida ❍☐ Polio
❍☐ Fractures ❍☐ Birth defects ❍☐ Spondylothiasis

Comments: ____

Immunologic

❍☐ Routine childhood immunizations ❍☐ Tetanus
❍☐ MRSA ❍☐ Vaccinations
❍☐ HIV ❍☐ AIDS

Comments: ____

Women only

O☐ Nipple discharge O☐ Premenstrual depression O☐ Menopause O☐ STD
O☐ Menstrual cramps O☐ Lumps in breasts O☐ Perimenopause O☐ LMP
O☐ Vaginal discharge O☐ Pap smear O☐ Hysterectomy O☐ Mammogram
O☐ HCG

Comments: ____

Men only

O☐ Nightly urination O☐ Prostate trouble O☐ STD O☐ ED
O☐ Difficulty starting urine O☐ Dripping after urination O☐ Prostate cancer

Comments: ____

Please provide copies of recent (within past year) lab work including TFT, Liver and Renal function tests, CBC and Lipid Profile. Also, copies of drug level monitoring and drug screens.

Current vital signs:

Height: ____________Weight:___________

BP: sit_________stand_______ P: ________R:________T:__________

Healthcare Provider name: (print) ________________________________ Title____________________

Healthcare Provider Signature__________________________________ Date____________________

Tuberculosis Risk Assessment

The Centers for Disease Control and Prevention and the United States Public Health Service recommend that tuberculosis skin testing be performed on all individuals who may be at increased risk of tuberculosis as a result of a medical condition or previous residence in a country with an increased prevalence of tuberculosis. Hopewell requests that you or your physician review these risk factors and symptoms and perform testing as appropriate. A two-step TB test (or blood test or chest x-ray as medically appropriate) is required prior to admission to Hopewell for any client that is at high risk for TB or who has symptoms of TB as determined by a physician.

Possible Symptoms of Tuberculosis:

- Unexplained weight loss
- Unexplained elevation of temperature for more than one week
- Unexplained night sweats
- Unexplained persistent cough for more than 3 weeks
- Unexplained cough productive of bloody sputum

Risk Factors for Tuberculosis Infection:

- Close contact with a known case of active tuberculosis
- Use of illegal injected drugs
- HIV (Human Immunodeficiency Virus) Infection
- Health Care Worker (direct medical patient care)
- Resident of employee in a congregate living setting (nursing home, homeless shelter, correctional facility)

Risk Factors for Tuberculosis Disease:

- Diabetes Mellitus
- Lymphoma, leukemia or cancer of the head, neck or lung
- Chronic kidney failure
- Silicosis
- Gastrectomy or jejuno-ileal bypass
- Long term immunosuppressive therapy
- Greater than 10% below ideal body weight

Areas with a High Prevalence of Tuberculosis as defined by the World Health Organization and the state health department.

You may be at risk if you lived in or traveled for 30 days or more to the following countries in the past five years:

- **Africa**-All countries
- **Asia/Southeast Asia/Pacific Islands**-All countries
- **North, Central & South America**-Argentina, Bahamas, Belize, Bolivia, Brazil, Costa Rica, Columbia, Dominican Republic, Ecuador, El Salvador, Guatemala, Guyana, Haiti, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Suriname, Venezuela
- **Europe**-Belarus, Bosnia-Herzegovina, Bulgaria, Croatia, Estonia, Hungary, Latvia, Lithuania, Macedonia, Moldova, Poland, Portugal, Romania, Russian Federations, Serbia, Slovak Republic, Slovenia, Ukraine, Yugoslavia
- **Middle East**-Bahrain, Iran, Iraq, Israel, Jordan, Kuwait, Lebanon, Oman, Qatar, Saudi Arabia, Syrian, Arab Republic, Turkey, Yemen

Nursing Department Services at Hopewell

Hopewell's nursing department includes a Nurse Manager (RN) and two LPN staff. 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 (Parkway Pharmacy) 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 even 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 transportation coordinator at x122 for more details on our transportation policy.
- 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. For non-urgent issues the nurse manager can be contacted at extension 106 and the LPN staff can be contacted at extension 111.

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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)

____

____

____

____

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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: ____

____

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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

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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: ____________________

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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: **[X]** receive from, **[X]** disclose to:

______________________________ ______________ ____ ________
(Name of Organization/Person & Relationship) **City** **State** **Zip Code**

Phone # ______________________ **Fax #** ______________________

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

Description of Information to be released:

[ ] Diagnostic Assessment & Update
[ ] Psychiatric Examinations
[ ] Psychological Evaluations
[ ] Nursing Assessment
[ ] Health History & Physical
[ ] Treatment Plans
[ ] Orders
[ ] Consultations
[ ] Quarterly Report
[ ] Drug Screens/Treatment
[ ] Information Shared During Staffing
[ ] Progress Notes
[ ] Lab Results
[ ] Discharge Summaries
[ ] 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 redisclosed 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 redisclosed to other parties.

______________________________ ____________
Signature of Individual **Date**

______________________________ ______________ ____________
Signature of Guardian/Personal Representative **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: ______________________

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Resident Name ______________________________ **PIN N/A Date**____________

Strengths/Resources

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:___________________________________

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Needs

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:________________________________

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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**_________

HOPEWELL
a therapeutic farm community

9637 State Route 534, P.O. Box 193
Mesopotamia, Ohio 44439
P. 440-426-2000 F. 440-426-2002
www.hopewellcommunity.org

Resident Name ______________________________ **PIN N/A** **Date**___________

Abilities

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.

- ☐ 1. I am very motivated for treatment
- ☐ 2. I am able to make an appropriate transition to living in a recovering community
- ☐ 3. I have good interpersonal/communication skills
- ☐ 4. I have good emotion-management skills
- ☐ 5. In the past I have demonstrated openness and honesty with regard to my recovery
- ☐ 6. I have been able to let go of the denial that I once had about my mental disorder
- ☐ 7. I have been able to let go of the denial that I once had about my substance abuse
- ☐ 8. I have some insight into my substance abuse and mental disorder
- ☐ 9. I have good self-esteem
- ☐ 10. I have some positive plans and goals for my future
- ☐ 11. I am willing to do what it takes to be in recovery
- ☐ 12. I have good work skills doing ______________
- ☐ 13. I'm aware of how work effects benefits
- ☐ 14. I'm aware of supports/resources in my community
- ☐ 15. I have a good relationship with a higher power
- ☐ 16. In spite of past hardships, there are still areas of my life in which I take pleasure
- ☐ 17. I am a helpful caring person, capable of offering support to others in recovery
- ☐ 18. Able to function in groups
- ☐ 19. Good grooming hygiene & self-care
- ☐ 20. I'm generally physically fit
- ☐ 21. Good spiritual practice, e.g., prayer, yoga
- ☐ 22. I can teach or offer my experience in _________
- ☐ 23. I have already overcome obstacles in my life
- ☐ 24. Special talents __________________________
- ☐ 25. I am knowledgeable in ___________________
- ☐ 26. Others: ______________________________

____

Preferences/Expectations

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.

- ☐ 1. I will learn the skills to stay mentally stable
- ☐ 2. I will learn the skills to stay clean and sober
- ☐ 3. I will have a better understanding of my diagnosis
- ☐ 4. I will be able to communicate more effectively
- ☐ 5. My interpersonal skills/relationships will improve
- ☐ 6. I will develop a system of support in recovery
- ☐ 7. I will be able to better manage my emotions
- ☐ 8. I will be able to better manage my anger
- ☐ 9. My health will improve __ physically__ mentally
- ☐ 10. I will have a better understanding of relapse prevention
- ☐ 11. I will have an illness management plan
- ☐ 12. I will learn how to reunite with my family
- ☐ 13. I will learn to get a job
- ☐ 14. I will learn ways to live well & be happy
- ☐ 15. Personal safety plan preferences
  - PRN meds ____
  - Physical restraint ____
  - Open quiet room ____
- ☐ 16. I will learn self-advocacy & empowerment
- ☐ 17. I will learn how to engage in activities I enjoy
- ☐ 18. I prefer to work in
  - Large Groups ___
  - Small Groups ___
  - Individually ___
- ☐ 19. Exercise in class, with equipment, inside or outside
- ☐ 20. Spiritual/religious preference _______________
- ☐ 21. Less help will be needed from case mangers & staff
- ☐ 22. I will stay out of the hospital
- ☐ 23. I will take my medication as prescribed
- ☐ 24. I will use coping skills instead of self-harming
- ☐ 25. Others: ______________________________

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