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
Residence (market value) ……..……..	
Other real estate (market value) ……..…….....	
Business / Farm assets ……	
Checking…….	
Savings ……..	
Stocks/Bonds/Investments (**not retirement accounts**)	
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 <u>Psychiatric</u> Prescribed MEDICATIONS:

<u>Please write-in below or attach a current medication record</u>

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: _____

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	[ ] Treatment Plans	[ ] Information Shared During Staffing
[ ] Psychiatric Examinations	[ ] Orders	[ ] Progress Notes
[ ] Psychological Evaluations	[ ] Consultations	[ ] Lab Results
[ ] Nursing Assessment	[ ] Quarterly Report	[ ] Discharge Summaries
[ ] Health History & Physical	[ ] Drug Screens/Treatment	[ ] 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	**Needs**
What are some things that help you? Check all that apply and list others you think will help.	**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. 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:_____ _____ _____ _____	□ 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**_____

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: _____

_____

_____

_____