Membership Referral Form

To be completed by the referring agency.

202 E. 3rd Avenue
Rome, GA 30161
706-413-2323
elevationhouserome@gmail.com
www.elevationhouse.org

Referral's Name: ______________________________

SSN: ____________________ DOB: ____________________

Address: ____________________ Phone: ____________________

Email: ____________________ Cell: ____________________

Medicaid? YES □ NO □ Medicaid Number: ____________________

Living Situation: Independent □ With Relatives □ Boarding Home □ Homeless □

Referred By: ______________________________

Agency/ Organization: ____________________ Date: ____________________

Address: ____________________ Phone: ____________________

Email: ______________________________

Treating QMHP Signature: ______________________________

If inpatient facility referral, include outpatient service provider: ____________________

Date of Follow-up: ____________________

NOTE: Please provide a copy of the referral's current Behavioral Assessment and Medical Necessity. Included? YES □ NO □

Date of last Hospitalization: ____________________ Where? ____________________

Primary Diagnosis: ______________________________

Other Diagnoses: ______________________________

Medication(s) (or attach list): ______________________________

Psychosocial Barriers: ______________________________

Reason for Referral (check all that apply):

□Basic Living Skills □Therapeutic Socialization Skills □Interpersonal Skills
□Prevent Psychiatric Hospitalization □Managing Symptoms that interfere w/ Education/Employment
□Prevent Isolation □Employment Support □Independent Living Support
□Increase Self-Confidence/Motivation □Improve Cognitive/Concentration Skills
□Mental Illness Management □ Reduce Negative Symptoms □Develop Recovery Plan
□Prevocational Training □ Medication Support/Education/Compliance

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Does the referral have a history of (check all that apply):

□Violent Behavior □Suicide Attempts
□Alcohol/ Drug Abuse □Sexual Misconduct

Please provide a brief explanation of those that are checked above:

Has the referral been charged/ convicted of a felony? Yes ☐ No ☐ If yes, please explain:

Membership Application

To be completed by the prospective member

202 E. 3rd Avenue
Rome, GA 30161
706-413-2323
elevationhouserome@gmail.com
www.elevationhouse.org

Applicant's Name: ______________________________

SSN: ______________________ DOB: ______________________

Address: ______________________________

Email: ______________________ Phone: ______________________

Cellphone: ______________________________

Race (check all that apply): □American Indian or Alaskan Native □Asian □Black or African American □Native Hawaiian or Pacific Islander □White □Other: ______________________

Ethnicity: □Hispanic □Non-Hispanic

Primary Language: ______________________

Gender: □Male □Female

Marital Status: □Single □Married □Divorced □Widowed

Living Situation: □Independent □With Relatives □ Boarding Home □ Homeless

Spouse's Name: ______________

Emergency Contact (1): Name: ______________________ Phone: ______________________

Relationship: ______________________

Emergency Contact (2): Name: ______________________ Phone: ______________________

Relationship: ______________________

Children? Yes □ No □

Please list the names and ages of your children:

Currently Employed? Yes □ No □

Where?______________________ How Long?______________

Please provide 5 year Employment History- names of employers, dates worked and positions:

Current Source(s) of Income:

Monthly Income: $____________

Highest Level of Education Completed: ______________________

Reason for wanting to become a member (check all that apply): □Basic Living Skills □Therapeutic Socialization Skills □Interpersonal Skills □Prevent Psychiatric Hospitalization □Managing Symptoms that interfere w/ Education/Employment □Prevent Isolation □Employment Support □Independent Living Support □Increase Self-Confidence/Motivation □Improve Cognitive/Concentration Skills □Mental Illness Management □ Reduce Negative Symptoms □Develop Recovery Plan □Prevocational Training □ Medication Support/Education/Compliance

Health History- Family Practitioner: ____________________

Address: ____________________

Phone: ____________________

Date of Last Visit: ____________________

Psychiatrist: ____________________

Agency/ Organization: ____________________

Address: ____________________

Phone: ____________________

Date of Last Visit: ____________________

Primary Diagnosis: ____________________

Other Diagnoses: ____________________

Please list all current medications:

What do benefits do you hope to get out of being a member of Elevation House?

Are you currently clean and sober? Yes ☐ No ☐

If no, when did you last use street drugs or alcohol, and what did you last use?

Have you been charged/ convicted of a felony? Yes ☐ No ☐

If yes, please explain:

Elevation House, Inc.
Member Rights and Responsibilities

PURPOSE:

To assure that all Members of Elevation House, Inc. (EHI) are informed of their rights and that such rights are respected throughout the Members involvement with EHI.

POLICY:

All individuals requesting services from (EHI) have a right to receive such service without regard to race, ethnicity, age, color, religion, creed, gender, national origin, sexual orientation, veteran status, financial condition, handicap or disability, HIV infection- whether asymptomatic or symptomatic, AIDS related complex or AIDS. No distinction will be formulated in determining eligibility for participation in services provided by EHI based on any of these identifiers, conditions or circumstances.

All individuals requesting services from EHI shall receive a ***Statement of Member Rights*** as part of the intake and initial orientation process, and, if appropriate, on an annual basis said statement shall conform to all applicable regulations issued by State, Federal and other funders. The following information is taken from the Georgia Department of Mental Health and is applicable to the Member of Elevation House.

Your Rights:

- You have a right to be informed of your rights.
- You have right to be informed regarding methods of resolving possible violations of your rights.
- You may seek advice and assistance from the Client Advocacy Program of the State of Georgia.
- You may contact an attorney of your choice.
- You have the right to be free from abuse, financial or other exploitation, retaliation, humiliation, and neglect;
- You have the right to access pertinent information in sufficient time to facilitate your decision making.
- You have the right to informed consent, refusal or expression of choice regarding service delivery, release of information, concurrent services, and composition of service delivery team.
- You have the right to access or referral to legal entities for appropriate representation, self-help support services, and advocacy services.
- You are entitled to a safe and humane environment.
- You have a right to as much freedom of movement as possible. This right may be limited only when it is necessary for the protection of you, others, and the community.
- You have the right to refuse treatment/therapy unless required by law.
- You have a right to participate in the formulation of your plan of care and to know the names of the staff members with whom you work with.
- You have a right to choose your rehabilitation provider and to discontinue your participation when you choose to.
- You have the right to refuse participation in any research project.
- You have a right to know the cost of your treatment and to know the source of any assistance available in meeting these expenses.
- You have a right to have all information concerning your treatment kept confidential

except when State law permits disclosure.
- You may report any suspected abuse or neglect or exploitation of patients without fear or reprisal.
- In exercising your rights, you may not infringe on the rights of others. You also have certain basic responsibilities and you have a right to know what is expected of you.

<u>Your Responsibilities</u>:
- Actively participate in your rehabilitation and help to develop your plan of care with an Elevation House staff member.
- Take part in planning and participating in your own psychosocial rehabilitation program and provide information concerning your mental health and medical history.
- Attend scheduled unit meetings at the Clubhouse and to select the unit ·of your choice to participate in.
- Contact Elevation House staff if you· are going to be absent from the program. Cancel your transportation, if applicable, as soon as you know you will be unable to attend the program.
- Ask a question(s) when you do not understand what is happening to you.
- Let a member of the staff know when you have a problem or feel sick.
- Show respect for the property and rights of others. ·
- Obey the laws which apply to all citizens.
- Be familiar with and observe the rules and policies of Elevation House.
- Accept responsibility for your actions.
- Cooperate with the goal of achieving self-sufficiency in the management of your everyday living.

As a member of Elevation House you have a guaranteed right to a place to come, a guaranteed right to meaningful relationships, a guaranteed right to meaningful work and a guaranteed right to a place to return.

Grievance - Perceived Violation of Member Rights: The Executive Director shall serve as Member Rights Representatives for Elevation House and shall function in this capacity as specified in the Member Grievance Policy.

Elevation House, Inc.
Notice of Privacy Policy

POLICY:

Elevation House, Inc. (EHI) will ensure the confidentiality of all information of persons served that is collected, stored, and disseminated by all EHI employees.

DEFINITION:

For all persons served, a release of information may be authorized by:

A. The person served themselves as outlined in federal and state regulations.
    1. A guardian who has been granted specific authority by law for adults that have been adjudicated incompetent.
        a. EHI reserves the right to request at any time a copy of any legal document(s) to support the above.

POLICY INTERPRETATION:

The Executive Director or designee shall be responsible for the interpretation of this policy.

PROCEDURE AUTHORITY:

The Executive Director or designee shall establish procedures to fully implement compliance with this policy.

PROCEDURE:

A. All information in a record of a person served is considered confidential and shall be available only to authorized recipients.

B. Limited information regarding the status of a person served may be released to the next of kin of the person served when it has been determined that such disclosure i in the best interest of the person served.

C. Confidential information may be disclosed as part of certain legal proceeding as follows:

1. If a Court issues a written order compelling disclosure; provided, however, that if a Court issues a subpoena or court order for records relating to alcohol and/or drug abuse treatment, then the appropriate stall person will go before the Court and advise the court that a team meeting should be held to determine where there is good cause to require disclosure of the record.

2. The staff person who answers the subpoena will take a copy of the federal regulations for reference for the presiding judge.

3. If a Court issues a witness subpoena requiring the recipient to appear and testify at a court proceeding, the recipient must appear at the proceeding at the specified date, time and place. If the proceeding is a trial or other hearing in court and the person served attends the proceeding the person served will have the opportunity to raise claim of “privilege“ or “confidentiality". The court will then determine if the recipient must testify. If the person served does not attend the proceeding and has not authorized the release of the information the recipient shall alert the court that the testimony contains privileged or confidential information and the person served has not authorized the release of information. It will be the judge who has the responsibility to decide if the recipient must testify.

4. For purposes of filing a petition for involuntary commitment, or a petition for adjudication of incompetence and the appointment of a guardian.

5. If the person served is voluntarily admitted or involuntarily committed and facing a district court hearing , such information as may pertain to the necessity for admission or continued stay in the facility.

6. If the information is relevant to litigation involving EHI and relating to the operation or services of EHI.

7. So called " re-disclosures" of information in records of the person served derived from other sources under conditions of confidentiality will be treated exactly like other disclosures.

8. Additional legal counsel may be sought when special or unusual information about an individual person served is requested by the courts, public officials, investigative units, or law enforcement bodies.

D. Confidential information indicating that physical or sexual abuse of children, disabled persons, or others identified in mandatory reporting statues is occurring or has occurred must be disclosed to the appropriate authorities as authorized by relevant statues.

E. Confidential information may be disclosed with the signed authorization of the person

served as part of the care and treatment of an individual as follows:

1. Information may be shared among employees, students, volunteers and consultants of EHI who have a need to know for reason of shared treatment, supervision, and quality assurance, or billing.

2. Information may be shared with other state facilities upon written determination by a responsible professional that such disclosure is necessary to coordinate appropriate and effective care, treatment, or habilitation of the person served, and/or that failure to share information would be detrimental to the care and treatment or habilitation of the person served.

3. Information may be shared with a physician or other healthcare provider who is providing emergency medical services to a consumer.

F. Confidential information may be disclosed without the authorization of the person served with regard to payment by a third party for services provided to the person served. Such information shall generally be limited to what is necessary to document the type and amount of service provided, that the person served is eligible for services, and that services were provided in accordance with the standards established by the payer. information may be shared with authorized personnel and/or designated agents of the South Carolina Department of Health and Human Services and the South Carolina Department of Mental Health with regard to persons served in part with public funds. Information may be shared with authorized agents of Medicaid, Medicare, commercial insurance carriers, employer s who self-insure for health benefits and other organizations/agencies who agree to pay for services provided by EHI.

G. Confidential information may be disclosed with the authorization of the person served when a responsible professional determines that in their opinion there is imminent danger to the health and /or safety of the person served, of another individual, o r there is likelihood of the commission of a felony or violent misdemeanor. Information may be disclosed to a potential victim of violence or danger to relatives or others who may be in a position to protect or deter the person served, to the police or courts, or other guardians of the public safety, and to others as appropriate. The responsible professional shall review the federal regulations (42 C.F.R., Part II) as they apply to duty to warn. An administrative review is necessary on all records when information is disclosed as a duty to warn.

H. Upon admission and updated yearly thereafter, all members of the Clubhouse are requested to sign a release of information giving EHI per mission to publish their names, photographs and articles they may write or be included in the " EHI News." This al so includes the use of photographs on the GHJ website, brochures, or other audio/visual presentations. If said release is not signed by a person served or representative, no such information or likeness of said person served will be used in any of the aforementioned media.

I. EHI and the local mental health centers have a written contract to freely share confidential information regarding persons served. EHI staff are prohibited from releasing any confidential information regarding a per on served that was obtained from another source without obtaining the written informed consent of the person served.

J. All EHI staff are required to sign a statement that they have read and understand the policies and procedures.

K. All consents to release information must be with informed consent and voluntarily given. Persons served or their designated responsible person shall be told that the provision of service is not contingent upon such consent and the need for such release.

EHI may disclose the admission or discharge of a person served whenever the designated responsible professional makes the determination that disclosure is in the best interest of the person. Request for admission or discharge must be in written form.

Elevation House, Inc.

Consent & Release Form

Consent to Treatment: ◻ **Accept** ◻ **Decline**

Consent and authority is hereby given to Elevation House, Inc. and its staff to perform Rehabilitative Psychosocial Services and/or related mental health services and treatments deemed necessary by appropriate members of the professional staff as authorized in consultation with me. This statement has been fully explained to me and I understand it.

Notice of Privacy Practices: ◻ **Accept** ◻ **Decline**

I have been provided a copy of the Elevation House, Inc. Notice of Privacy Practices and an opportunity to review it and ask questions.

Member Handbook/Member Rights & Responsibilities: ◻ **Accept** ◻ **Decline**

I have been provided a copy of the Member Handbook and Member Rights and Responsibilities and was provided an opportunity to review and ask

Photograph/ Video Release: ◻ **Accept** ◻ **Decline**

I hereby authorize Elevation staff and members to videotape me and take photographs of me to use for informing other members, family members and the general public about the services and opportunities available through Elevation to include: social media, bulletin boards, displays, website, etc.

I further authorize that my full name and photograph be used in Elevation House media, reports and publications.

Family/ PCP Release: ◻ **Accept** ◻ **Decline**

I herby give Elevation staff permission to communicate with my family or primary care provider regarding the services I receive at Elevation House as it relates to my progress and plan of care.

By signing below, I indicate that I hereby understand and agree to all of the above marked statements and acknowledge that this consent is truly voluntary and valid. I further acknowledge that I may revoke this consent at any time except where actions based on prior consent have already taken place.

Member Signature: ______________________________________ Date:_________________

Witness Signature: ______________________________________ Date:_________________

Title/ Position:_____________________________________