COMMUNITY MEDICAL RESPITE PROGRAM

SOUTH WILMINGTON ST. CENTER
1420 S WILMINGTON ST
RALEIGH, NC 27603
919-857-9428

THE RALEIGH RESCUE MISSION
314 EAST HARGETT STREET
RALEIGH, NC 27601
919-828-9014

Attention Medical Provider:

The **South Wilmington Street Center** provides emergency medical respite assistance for homeless **males** and **The Raleigh Rescue Mission** provides emergency medical respite assistance for homeless **females and males** who require medical respite for physical recuperation following minor surgery or serious illness. Any medical assistance and special transportation must be arranged by the referring provider prior to discharge, and the referring provider must provide us written doctor's orders regarding the guest's stay **prior to arrival of the guest at our facility**. The referral guidelines to access these beds are below and may be requested by doctors, nurses, social workers, or discharge planners from the medical provider.

To make referral:

1) The Referral Form must be complete and,
   a. **Have guest sign and complete the Release of Information Form** and,
   b. **Have guest sign and complete the Medical Respite Agreement Form.**
   c. Any additional information you can provide is welcome.
   d. **Written doctor's orders for accepted referrals are required.**
2) **For Females:** Contact the Medical Respite Social Worker on duty at **919-633-9791** to inform them a referral packet is coming and then **fax** the completed referral packet to 919-341-5680 (Attn: *Brooks Ann McKinney*). If there is a bed available and the patient is accepted discharge orders should be faxed to 919-743-0580 (Attn: Dr. Hartye at Horizon Health Clinic.)
3) **For Males:** Contact South Wilmington St. Center at **919-857-9428** to inform them a referral packet is coming and then **fax** the completed referral packet to 919-857-3867. (Attn: *Blanche Royall*) If there is a bed available and the patient is accepted discharge orders must be faxed to 919-743-0580 (Attn: Dr. Hartye at Horizon Health Clinic.)
4) **DO NOT** send a guest to the facility with a referral packet or doctor's note requesting respite.
   a. The referral packet must be approved by us prior to our accepting the guest at the facility.
   b. We will make every effort to accept or deny a completed referral form in a timely manner.
   c. Referrals will be accepted Monday – Friday, 8:00am to 5:00pm. Call cell phone on weekends if needed.
5) Communicate to the patient that, if accepted, they will be required to:
   a. Attend an onsite orientation of program rules the first day of their stay;
   b. After their medical respite time has ended they may be eligible to remain at the South Wilmington Street Center if they have completed all program requirements and/or space is available (requirements will be provided during orientation); or remain at the Raleigh Rescue Mission if space is available.
   c. Remain alcohol and drug free;
   d. Limit personal belongings;
   e. Comply with all Medical Respite Program Rules and Expectations.

Please remember that there is high demand for these beds and incomplete information will delay our decision. These beds are intended for guests who need to remain in bed. Guests in these beds will not be allowed to come and go from the Center except for documented medical appointments. Guests who do not follow protocols and rules will be asked to leave. If the guest requires medical respite for an extended time (more than 2 weeks) then our Center may not be appropriate.

We are happy to offer this service to the community, and we hope we can make this work to the benefit of all. Please feel free to contact us if you need any additional information regarding our respite service.

MEDICAL RESPITE REFERRAL FORM
South Wilmington Street Center and Raleigh Rescue Mission

Name:	Date of Birth:	SS#: MR#:
Referring Agent:	Cell/Pager:	Referring Agency:
Referring Provider:	Cell/Pager:	Office #:

1. Current Diagnosis:_____
   Chronic Illnesses:_____
   Prognosis:_____

2. **Social Services and Referrals:**
   Check all that apply:
   ☐Referred to Triangle Disability Associates _____(caseworker contact info)
   ☐Qualifies for social services (food stamps, disability, Medicaid)_____
   _____(list all)
   ☐Current benefits_____
   ☐Current Agencies and/or referrals_____

3. Substance Abuse/Mental Health Services: Open case with Crises and Assessment? ☐ yes ☐no (Wake Co. Human Service)
   SA/MH Counselor (Agency contact info)_____
   Mental Health Diagnosis_____ Drug/s of choice_____
   Prior treatment history_____

4. Number of Medical Respite Days requested: _____(not to exceed 14) days. (If patient is accepted into the Medical Respite program, this will be evaluated throughout their stay.)

5. ☐ The following clinic appointments have been made for the client (date, time, name of clinic, physician, and number):
   _____
   _____
   ☐ The client will need to contact the following clinics to make an appointment (name of clinic, physician, and number):
   _____
   _____

6. Check all that apply:
   ☐ Feeds, dresses, and bathes self ☐ Continent of bowel and bladder ☐ Not suicidal or homidical
   ☐ Independent mobility ☐ Not in active alcohol withdrawal ☐ No IV lines
   ☐ Certified as Homeless ☐ Able to administer own meds
   ☐ Behavior is appropriate & cooperative ☐ Client agrees to respite admission
   ☐ Client does not have impetigo, gastroenteritis, diarrhea, infectious respiratory condition, MRSA, C-diff

7. Level of Functioning:
   Physical: ☐ Independent ambulation ☐ Ambulates with assistance (Circle type: walker wheelchair crutches)
   ☐ Speech/Vision/Hearing Impairment (Specify): _____
   ☐ Skin Impairment (Specify): _____
   Activities of Daily Living:
   ☐ Independent with self-care
   ☐ Assistance required with:_____
   Primary Language: ☐ English ☐ Other (Specify):_____

8. Please list all discharge medications (name, dosage & frequency, to include insulin) or attach copy of discharge orders:
   _____
   _____
   _____

Patient must come with enough medication to cover length of stay at the Medical Respite – this is the referring medical provider's responsibility.

☐ Client has all discharge medications
☐ Client given enough medications for _____ days, until prescriptions filled
☐ Plan for client to obtain discharge medications: (where, when, how)

_____

_____

Specific Care Needs (check all applicable):

☐ Requires Daily Dressing Changes
- ☐ Wound care orders clear and precise
- ☐ Dressing supplies given at discharge
- ☐ Client instructed and will change dressings
- ☐ Home Health ordered to assist with dressing changes

Agency: _____ Ph: _____

☐ Requires Oxygen (4 liters or less):

☐ Liter flow: _____ ☐ Continuous ☐ With sleep/exercise ☐ Other

Specify: _____

Medical Company: _____ Ph: _____ ☐

Requires Nebulizer:
- ☐ Instructed on use of machine and medication dosage and times
- ☐ Has medication and machine for nebulizer at discharge

Medical Company: _____ Ph: _____

☐ Has medication ONLY. Machine has been ordered (see company above)

☐ Requires Diabetic Management:
- ☐ Received diabetic education, understands how to respond to high or low blood sugars
- ☐ Has glucometer and understands use of meter
- ☐ Has glucometer and strips until next clinic appointment
- ☐ Patient performs monitoring independently

☐ Requires Home Health visits:

Agency: _____ Ph: _____

☐ Requires Physical Therapy:
- ☐ Physical therapy arranged

Agency: _____ Ph: _____

☐ Requires Occupational Therapy:
- ☐ Occupational therapy arranged.

Agency: _____ Ph: _____

****

☐ **Requires Medically At Risk in Summer (MARS)** **Homeless persons who are medically at-risk are eligible to participate in the MARS White Flag Program. Persons who are medically at-risk have been diagnosed with illnesses such as diabetes, significant cardiac and respiratory disease, heart failure, Chronic Obstructive Pulmonary Disease, emphysema, asthma, angina, etc. In order to participate in MARS, a person must be evaluated at Horizon Health Center or through the Medical Respite Program in order to document such illness. If a person has never been seen at Horizon, he or she must take a photo ID and a letter from a shelter or Cornerstone stating that he or she is homeless.**

Facility: _____

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Referring Provider's Checklist :
- ☐ Referring Provider has read and understands the "Attention Medical Provider" cover letter
- ☐ Referring Provider has explained and had the guest sign the "Medical Respite Agreement" form
- ☐ Referring Provider has explained and had the guest sign the "Release of Information" form
- ☐ Referring Provider has (or will) completed doctor's orders and submitted to Medical Respite Social Worker

Signature of Referring Provider: _____

To be completed by receiving Medical Respite Staff:

Date Received: _____ Time Received: _____ Shift Supervisor Processing Referral _____ Initials _____

_____Approved _____ Denied

If denied, why? _____

Dorm/Bed # Assigned _____ Day/Time Guest is expected to arrive? _____ Doctor's Orders Received _____

Information entered Shift Synopsis ? _____ Release of Information Received? _____ Orientation Complete _____ HMIS Complete _____

Would pt have been sent to another facility in lieu of respite? _____ if yes, which facility _____

RELEASE OF INFORMATION

Medical Respite Program
South Wilmington Street Center and The Raleigh Rescue Mission

Guest Name: _____ Date of Birth: _____
First MI Last

I, _____ hereby authorize _____
(Guest Name) (Name/Address of Provider Agency)

_____

to release specified information in my records to (circle one) the SOUTH WILMINGTON STREET CENTER/Wake County Human Services or THE RALEIGH RESCUE MISSION. This data shall include:

- Diagnosis
- Treatment plan
- Medical history
- Diagnostic testing
- Lab results
- Identifying information
- Medications
- Doctor's orders

I understand that this information will be used for coordination of bed rest and medical services, temporary housing, and case management assistance.

Other information: This is a TWO WAY RELEASE FOR EXCHANGE OF INFORMATION BETWEEN THE ABOVE NAMED PARTIES

My right to confidentiality has been explained to me and I understand what information will be released, the need for the information and that State statutes and regulations protect the confidentiality of authorized information. In addition, information related to substance abuse in my records is protected under federal regulations and cannot be disclosed without my written consent unless otherwise provided in the 42 Code of Federal Regulations Part 2. I freely consent to the release on information as stated in this document.

This consent will expire on: _____ (specific date, event or condition, not to exceed more that 365 days from signature). I understand that I may revoke this consent at any time but that it will remain valid to the extent releases based on this consent have already occurred.

_____ _____
Client Signature Date Signed

_____ _____
Witness Date Signed

Client Signature Revoking Consent Date

MEDICAL RESPITE AGREEMENT

South Wilmington Street Center and The Raleigh Rescue Mission

The MEDICAL RESPITE PROGRAM is for homeless men and women needing short-term bed rest for physical recuperation following minor surgery or serous illness. Before being admitted, the Medical Respite Social Worker must have received and approved a Medical Respite Request Packet, including this form, a completed "Medical Respite Referral Form", and a release to exchange information between the Medical Respite staff and the Medical Provider signed by the client. These forms are available from the Respite Coordinator at 919-828-9014 ext 133 and must be completed and faxed to 919-341-5680 before any guest will be considered for admission.

Guests admitted to the Medical Respite Program are granted a specific length of stay. During your time in the program you will be required to:

- Attend an on-site orientation the first day of stay;
- Remain Alcohol and Drug Free;
- Continuously remain in the area designated except for meals, documented medical and other necessary appointments;
- Have any medical assistance and / or transportation arranged by referring practice and documentation provided to the Nurse;
- Please try to limit your personal belongings (Maximum 4 closed bags)
- Comply with all Medical Respite Program Rules and Expectations, provided upon the day of admission

2.) During your stay, you will also have an opportunity to complete a checklist for entrance into the Transitional Program, if space is available.

My Signature on this document indicates that I understand and agree to follow these guidelines during my stay in the Medical Respite Program. I understand I will be provided an orientation and Medical Respite Program rules and expectations on the first day of my stay.

Print Guest Name: _____

Guest Signature: _____ Date: _____

Witness Signature : _____ Date : _____

COMMUNITY MEDICAL RESPITE
DISCHARGE QUESTIONAIRE

Name: _____ Admit Date: _____ Exit Date: _____ Age____ Race_____

HOSPITALIZATION/ER VISITS

Days hospitalized in the last 30 days? _____ days Related to present condition(s)? ___Yes ___No
ER/ED visits in the last 30 days? _____ days Related to present condition(s)? ___Yes ___No
How many times has hospitalization/ER visits been required for present condition(s)?
Within the last 6 months _____
Within the last 8 months _____
Within the last year _____
Has hospitalization/ER visits been due to lack of follow up or proper care of illness/injury? ____Yes ____No
Which hospital(s) has resident been seen or hospitalized in? _____
Does resident tend to follow the instructions as given on their own? ____Yes ____No
If no, is lack of permanent living arrangements part of the reason? _____Yes ____No
If yes, please specify how it affects their ability to follow the doctor's medical instructions _____
_____

DIAGNOSIS

Illness _____ Specify type of illness _____ Broken Bone ____ Surgery ____
Gunshot wound ____ Knife wound _____ Other ____Specify other _____

Is illness/injury Chronic ____ or Acute ____

ABUSE/PSYCH ISSUES

Alcohol ☐ Psych ☐
Drugs ☐ None ☐
Other (Specify) ☐

_____
_____

SOCIAL SERVICES AND REFERRALS

Referred from? _____ Alternative care plan offered in lieu of Respite Program? ____Yes ____No
If yes what plan was offered and why was resident referred to respite program instead? _____
_____
Referred to Caseworker? _____ Agency referred to _____
Qualifies for social services (food stamps, disability, Medicaid) _____
_____
Current benefits _____
Current Agencies and/or referrals _____
_____

HISTORY OF HOMELESSNESS

Time homeless before coming to respite program
<1 month 1-6 months 7-11 months 1-3 years >3 years

WHERE DID RESIDENT SLEEP BEFORE HOSPITALIZATION?

Street/Abandoned Building Family/Friends Hotel/Motel Treatment Program
Own house/apartment Shelter Trans Housing Vehicle
Prison/Jail Other_____ Unknown

REASON FOR EXIT

Completed treatment Death Admitted to Hospital Left AMA
Substance abuse Unknown Other_____

Did Resident stay for entire plan? _____Yes ____No If no, why not? _____
Has stay in program improved resident's condition? ____Yes ____No If no, why not? _____
Has stay in program helped resident follow medical instructions? ____Yes ____No If no, why not? _____
_____
In resident's opinion, has stay in program reduced chances of hosp/ER visits? ____Yes ____No If no, why not? _____
_____
In nursing staff's opinion, has stay in program reduced chances of hosp/ER visits? ____Yes ____No If no, why not? _____
_____
Did the Community Medical Respite Program avoid the need for Emergency Transportation? (Ambulance Calls) ___Yes ___No

HOUSING STATUS AT TIME OF EXIT

Section 8 housing transit housing Shelter Treatment Program Friends/Family
Hotel/Motel Hospital Prison/Jail Nursing Home Housing-Other Street
Unknown

FAX

NC Coalition to End Homelessness
Attention: Susanna Birdsong

Fax number: 1.888.742.3465

From: Monique Stokes, Administrative Assistant

Raleigh Rescue Mission
Medical Respite Service
Nurse- Pennie Arnold, RN-BSN
314 E. Hargett Street
Raleigh, NC 27601
919.828.9014 ext 133

Fax number: 919.341.5680

Date: 7/14/09

Regarding: Mental Health Respite Referral Forms

Number of pages: 6 (incl. Cover)

Comments:

Thank You!

MENTAL HEALTH RESPITE PROGRAM

THE RALEIGH RESCUE MISSION
314 EAST HARGETT STREET
RALEIGH, NC 27603 RALEIGH, NC 27601
919-828-9014X133
919-400-3414

The Mental Health Respite Program is a comprehensive array of services designed to stabilize the conditions of acute or severe psychiatric symptoms of homeless individuals upon release from an inpatient hospital. It is a voluntary program, provided in a shelter based community. This service is intended for persons whose condition can be stabilized with short-term intensive services. The goal of the MHRP is to stabilize the crisis situation as quickly as possible and to prevent unnecessary inpatient re-hospitalization. We view inpatient hospitalizations as the treatment option of last resort.
All consumers are evaluated by their needs and will follow a Progression Plan once entered into the program.

Our program is staffed twenty-four (24) hours a day in a local homeless shelter. This service provides respite for mentally ill adults whose community placement would be threatened without 24 hour services; or who require more intense supervision / medical management than is available in the community.
We connect client with local agencies to provide holistic services. The hours of participation will be based on individual needs.

Admission Criteria

- **Homeless and can receive IPRS funding**
- **No longer a danger to oneself or others.**
- **Ability to access medications required for treatment-Must have medication in hand for a minimum of 14 days.**
- **Need of a safe environment that is less restrictive than inpatient psychiatric hospitalization. No longer meeting criteria for admission.**
- **Deterioration in psychiatric condition or environment, which may, if not addressed, result in severe exacerbation of symptoms leading to potential hospitalization or loss of community placement-**
- **Have a diagnosis of mental illness and/or substance abuse**
- **Be willing to be treated voluntarily**
- **Be medically stable, not in active alcohol withdrawal**
- **Agree to a personal belongings inventory and person search upon admission**
- **Agree to a urine drug screen if there is suspicion of substance abuse**
- **Be 18 years of age or older**
- **The referring professional / agency has a firm plan for client service disposition upon discharge from MHRP.**

Exclusions:

- **No active homicidal ideations and excessive violent acting-out behaviors**
- **Suicidal ideations**
- **Specialized medical services or intensive nursing care for clients on renal dialysis, tube feeding, or IV lines.**
- **Clients who are unable to care for themselves or perform routine activities of daily living.**
- **Clients with infectious/contagious diseases that require special isolation precautions.**
- **Clients who are incontinent of urine and/or feces.**
- **Clients required PRN medications**
- **Clients who have have been in seclusion or restraints within 48 hours of discharge.**

Protocol

1. Call Respite RN at 919-400-3414 to see if bed is available
2. Fax referral form and discharge orders/continuing care plan to 919-341-5680.
3. Insure that medications are provided.
4. Connect mental health agency with MH Respite Case Manager.
5. Make sure contract of services is agreed upon.
6. Provide transportation to facility.

MENTAL HEALTH RESPITE REFERRAL FORM
Raleigh Rescue Mission

Name:	Date of Birth:	SS#: MR#:
Referring Agent:	Cell/Pager:	Referring Agency:
Referring Provider:	Cell/Pager:	Office #:

Steps to a Respite referral:

***Mon-Fri:** 1. Contact nurse 919-400-3414 **BEFORE** completing referral form to see if bed is available.
2. Fax Referral Form + D/C Med Form (inpt) + ADL record (inpt) to MHRP at 919-341-5680
3. Insure that medications are supplied for at least 14 days.
4. Connect MH agency to MH social worker.
5. Make sure contract of services is agreed upon.
6. Provide transportation to facility.

1. Current Diagnosis:_____
Chronic Illnesses:_____
Prognosis:_____
Axis I_____
Axis II_____
Axis III_____
Axis IV_____
Axis V_____

Medical Provider to Complete all Following Sections

2. **Admission Criteria – Check Boxes Below (must meet all criteria)**

Homeless		Willing to see Respite RN qd and can comply with medial recommendations	
Acute medical problem that would benefit from short-term Respite care (14 days)		Behaviorally appropriate for group setting (including no Known suicidal or assaultive risks)	
Independent in ADL's including mediation administration		No intravascular lines (IV lines)	
Independent in mobility (cane, walker, wheelchair)		Does not require > 6 – week respite stay	
Continent of urine and feces		Does not need SNF placement	
Medically stable		Patient agrees to Respite admission	
Is not in active alcohol/drug withdrawal		Diabetics have supplies	

3. **Social Services Referrals:**
Check all that apply:
☐Referred to Triangle Disability Associates _____(caseworker contact info)
☐Current benefits client is receiving _____
☐Current Agencies _____

5. Substance Abuse/Mental Health Services: Open case with Mental Health Agency? ☐ Yes ☐ No
SA/MH Counselor (Agency contact info)_____
Mental Health Diagnosis_____
Drug/s of choice_____

Prior treatment history_____

6. Number of Days requested: _____(not to exceed 14) days.

7. Follow up appointments made prior to discharge:
_____
_____
_____
_____

8. Level of Functioning:
Physical: ☙ Independent ambulation ☙ Ambulates with assistance (Circle type: walker wheelchair crutches)
☐ Speech/Vision/Hearing Impairment (Specify): _____ ☙ Skin Impairment (Specify): _____ Activities of Daily Living:
☐ Independent with self-care
☐ Assistance required with:_____ Primary Language: ☙ English ☙ Other (Specify):_____

9. Please list all discharge medications (name, dosage & frequency, to include insulin) or attach copy of discharge orders:
_____
_____
_____

Patient must come with enough medication to cover length of stay – this is the referring provider's responsibility.

☐ Client has all discharge medications
☐ Client given enough medications at least 14 days.
☐ Plan for client to obtain discharge medications: (where, when, how)
_____
_____

Specific Care Needs (check all applicable):
☐ Requires Daily Dressing Changes
☐ Wound care orders clear and precise
☐ Dressing supplies given at discharge
☐ Client instructed and will change dressings
☐ Home Health ordered to assist with dressing changes
Agency: _____ Ph: _____ ☙ Requires Oxygen (4 liters or less):
☐Liter flow:_____ ☙ Continuous ☙ With sleep/exercise ☙ Other Specify: _____ Medical Company: _____ Ph:_____ ☙ Requires Nebulizer:
☐ Instructed on use of machine and medication dosage and times
☐ Has medication and machine for nebulizer at discharge
Medical Company:_____ Ph:_____ ☙ Has medication ONLY. Machine has been ordered (see company above)
☐Requires Diabetic Management:
☐ Received diabetic education, understands how to respond to high or low blood sugars
☐ Has glucometer and understands use of meter
☐ Has glucometer and strips until next clinic appointment
☐ Patient performs monitoring independently
☐ Requires Home Health visits:
Agency: _____ Ph:_____

☐ Requires Physical Therapy:
☐ Physical therapy arranged
Agency:_____ Ph:_____ ☙ Requires Occupational Therapy:
☐ Occupational therapy arranged
Agency:_____ Ph:_____

****

****

Referring Provider's Checklist:

- Referring Provider has read and understands the "Attention Medical Provider" cover letter
- Referring Provider has explained and had the guest sign the "Medical Respite Agreement" form
- Referring Provider has explained and had the guest sign the "Release of Information" form
- Referring Provider has (or will) completed doctor's orders and submitted to MH social worker

Signature of Referring Provider: _____

To be completed by receiving Medical Respite Staff:
Date Received: _____ Time Received: _____ Shift Supervisor Processing Referral _____ Initials _____
____Approved ____Denied
If denied, why?
Dorm/Bed # Assigned _____ Day/Time Guest is expected to arrive? _____ Doctor's Orders Received _____
Information entered Shift Synopsis ? ____ Release of Information Received? ____ Orientation Complete ____ CHINS Complete ____
Would pt have been sent to another facility in lieu of respite? _____, if yes, which facility _____

RELEASE OF INFORMATION

_____ and The Raleigh Rescue Mission

Guest Name: _____ Date of Birth: _____
First MI Last

I, _____hereby authorize _____
(Guest Name) (Name/Address of Provider Agency)

_____

to release specified information in my records to (circle one) the Mental Health Respite Program at THE RALEIGH RESCUE MISSION. This data shall include:

- Diagnosis
- Treatment plan
- Medical history
- Diagnostic testing
- Lab results
- Identifying information
- Medications
- Doctor's orders

I understand that this information will be used for coordination of bed rest and medical services, temporary housing, and case management assistance.

Other information: This is a TWO WAY RELEASE FOR EXCHANGE OF INFORMATION BETWEEN THE ABOVE NAMED PARTIES

My right to confidentiality has been explained to me and I understand what information will be released, the need for the information and that State statutes and regulations protect the confidentiality of authorized information. In addition, information related to substance abuse in my records is protected under federal regulations and cannot be disclosed without my written consent unless otherwise provided in the 42 Code of Federal Regulations Part 2. I freely consent to the release on information as stated in this document.

This consent will expire on: _____ (specific date, event or condition, not to exceed more that 365 days from signature). I understand that I may revoke this consent at any time but that it will remain valid to the extent releases based on this consent have already occurred.

_____ _____
Client Signature Date Signed

_____ _____
Witness Date Signed

Physician name and contact_____
_____

_____ _____
Client Signature Revoking Consent Date

Mental Health Respite Agreement

The Mental Health Respite Program is for homeless men and women needing short-term bed rest for mental health stabilization following mental health institutionalization. Before being admitted, the MH RN must have received and approved a referral packet, including this form, exchange information between the MHR staff and the provider signed by the client. These forms are available from the and must be completed and faxed to 919-341-5680 before any guest will be considered for admission.

Guests admitted to the Medical Respite Program are granted a specific length of stay. During your time in the program you will be required to:

- Attend an on-site orientation the first day of stay;
- Remain Alcohol and Drug Free;
- Continuously remain in the area designated except for meals, documented

- Have any medical assistance and / or transportation arranged by referring practice and documentation provided to the Nurse;
- Please try to limit your personal belongings (Maximum 4 closed bags)
- Comply with all MHR and expectations, provided upon the day of admission.

2. During your stay, you will also have an opportunity to complete a checklist for entrance into the Transitional Program, if space is available.

My Signature on this document indicates that I understand and agree to follow these guidelines during my stay in the Medical Respite Program. I understand I will be provided an orientation and Medical Respite Program rules and expectations on the first day of my stay.

Print Guest Name: _____

Guest Signature: _____ Date: _____

Witness Signature : _____ Date : _____