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| ABODE_BWLogo**Operation Comfort: Alameda County****DATE\_\_\_/\_\_\_\_/\_\_\_**  |
| Name (Full and Last): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Nick name/Name wish to go by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Participant # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Code \_\_\_\_\_\_ DOB\_\_\_/\_\_\_/\_\_\_ Age \_\_\_\_\_\_\_\_\_\_\_Contact Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City of Last Residence\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Partner’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Partners Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Where were you staying before you came here? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_What was the name of the Case Manager you worked with there? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_What other agencies do you currently receive services from? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| On Probation? Y N End Date\_\_\_\_\_\_\_\_\_\_\_\_ On Parole? Y N End Date\_\_\_\_\_\_\_\_\_\_\_ |
| Are there any health issues we should be aware of? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Do you need to see a doctor? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Health Conditions / History\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_TB Test in past 3 months? \_\_\_\_\_\_\_ Do you feel suicidal or homicidal? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_If applicable- Service animal name and breed. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Are You a Veteran? \_\_\_Yes \_\_\_ NoDietary Needs (vegetarian or non-vegetarian, other restrictions) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Notes:  |
| **Emergency Information** Participant Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Participant First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Contact Info\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_/\_\_\_/\_\_\_Age \_\_\_\_ Emergency Contact: Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Vehicle on Site? Y N Model/ Color\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ License Plate \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_List of all Allergies (medications, food, insects, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**List of all medications** (Please note that in the event of a medical emergency, this information may be shown to emergency responders)Name of Medication Reason for Taking \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Notes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_For staff use only:Room number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Page 2 |

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**AUTHORIZATION TO RELEASE AND OBTAIN INFORMATION**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby authorized Abode Services Operation Comfort: Alameda County to release information to and obtain information from: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. I further release Abode Services Operation Comfort: Alameda County from all liabilities that may arise from this authorization.

Information to be \_\_\_\_\_\_\_\_released and/or obtained:

\_\_\_\_ Income/Employment Status – Verification

\_\_\_\_Results of alcohol and/or drug testing

\_\_\_\_Medical History to include to HIV/AIDS status

\_\_\_\_Psychological/Psychiatric Features/Symptoms

\_\_\_\_Evaluation for Disability Claim – Disability Verification

\_\_\_\_In-Patient/Outpatient Substance Abuse Treatment History

\_\_\_\_Attendance/Participation in Case Management/ Counseling

\_\_\_\_Results of Mental Status Examination

\_\_\_\_Medical/ Psychiatric History/Treatment/Medication/Follow-Up/Hospitalizations

\_\_\_\_Transitional and/or Permanent Housing: \_\_\_History, \_\_\_\_\_Services, \_\_\_\_\_Search

\_\_\_\_Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that only the above mentioned information will be released or obtained for the following reasons(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and that my records are protected under federal regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent automatically expires six months from this date. My signature below indicates I have read the above contents, understand that I have a right to receive a copy of this authorization upon request and agree to the conditions stated herein. I also authorize the use of a telefax or photocopy of this form for the release of the information described above

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorizing Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Staff Witness Date

This information has been released /obtained from confidential records which are protected by law. Federal regulations prohibit making any further discloser of it without specific consent of the person to whom it pertains, or otherwise permitted by such regulations. General authorization is not sufficient for this purpose.



**PARTICIPANT GRIEVANCE POLICY**

If you have a complaint about the performance of Abode Services’ staff, program decisions, and/or you feel you have been treated unfairly, the following are the steps you should take to have your complaint heard.

1. Talk privately to the person with whom you have the problem. We encourage you to try first to work out the problem in an open and informal way.
2. If you do not feel comfortable talking with the person with whom you have the concern with, or you do speak with them and are not satisfied with the outcome, you may make an appointment to speak with or submit a written complaint (which may be in your own language) to the Manager/Director of the program you are currently in. The Manager/Director shall meet with you or provide you with a written response to your written complaint within five (5) working days of the meeting or receipt of your written complaint.
3. If you are still unsatisfied with the decision made, you may make an appointment to speak with or submit a written complaint (which may be in your own language) to Abode Services Executive Director or his/her designee. The Executive Director or his/her designee shall meet with you or provide you with a written response to your written complaint within five (5) working days of the meeting or receipt of your written complaint.
4. Or, if you prefer, you may bypass the above steps and immediately contact the funding agency below:

**Alameda County Health Care Services Agency**

**Administration Offices**

**1900 Embarcadero Cove, Oakland CA 94606**

**Attn: Director**

**510-271-9100**

WRITTEN GRIEVANCE FORMS CAN BE FOUND POSTED ON THE BULLETIN BOARD IN THE LOBBY.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

Participant Signature Date Staff Signature Date



**CONFIDENTIALITY AGREEMENT**

HTSS respects your right to privacy, everything shared with the Operation Comfort team is kept within the team and discussed only as needed to best serve you. There are a few instances under which we are required by law to break confidentiality. They are:

1. Your safety is at risk. If steps need to be taken to protect your safety (i.e., you plan to harm yourself) or someone else’s (i.e., you plan to harm someone else) the Operation Comfort team will break confidentiality to ensure that the appropriate emergency services are provided.
2. There is suspected child (anyone under 18 years of age) or elder (anyone over 65 years of age or a disabled dependent between the ages of 18-65) abuse/neglect.

Release of Information (ROI):

In order to best serve you, you may grant the Operation Comfort team permission to coordinate with other service providers involved in your care and/or contact individuals in your support system that can be helpful to you by signing a Release of Information (ROI). Please let us know if there is anyone you would like to complete an ROI for at this time.

Print Head of Household Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Head of Household Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

Print Program Staff Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Program Staff Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_



**Safety and Participation Agreement**

**I understand that I have the following rights as a guest of Operation Comfort: Alameda County.**

­­­­**\_\_\_\_\_\_** The right to be treated with dignity and respect;

**\_\_\_\_\_\_**The right to privacy within the constrictions of the hotel

**\_\_\_\_\_\_**The right to be treated with cultural sensitivity;

**\_\_\_\_\_\_**The right to self-determination in identifying and setting goals;

**\_\_\_\_\_\_**The right to receive services only in the context of a professional relationship based on valid, informed consent;

**\_\_\_\_\_\_**The right to be clearly informed, in understandable language, about the purpose of the services being delivered, including residents who are not literate and/or have limited-English proficiency;

**\_\_\_\_\_\_**The right to confidentiality and information about when confidential information will be disclosed, to whom and for what purpose, as well as the right to deny disclosure, unless disclosure is required by law;

**\_\_\_\_\_\_**The right to reasonable access to records concerning their involvement in the program.

**I understand that I have the following responsibilities as a guest of Operation Comfort: Alameda County**.

**\_\_\_\_\_\_ I understand that I am required to be in isolation at all times until I am medically cleared to leave. If I leave my room, I am putting other participants and staff at risk.**

**\_\_\_\_\_\_ I understand that the following consequences will occur** if I do not adhere to the isolation/quarantine order:

1. If a hotel guest (including household members) is seen leaving the room or allowing someone into their room, they will be verbally warned and reminded of the agreement. Staff will document the warning.
2. If this happens again, they will be given a written warning that they have violated the order and will be reminded of the agreement and told that they will lose certain privileges. Staff will document the warning.
3. If there is a third infraction, law enforcement will be called. If the guest chooses to leave, the guest’s former living situation (e.g., shelter or congregate living situation) will be notified that the guest left the isolation location against medical orders and they should not be allowed to return.

\_\_\_\_\_ I understand that if I use threats, harassment (of any kind), verbal or physical violence (including destruction of property) towards staff, volunteers, or another participant, I may be asked to leave the program immediately.

**\_\_\_\_\_ I understand that no weapons are allowed on the premises. If weapons are brought onto the property, I understand I will be asked to leave the program immediately.**

 **I understand that it is my responsibility to store my medications securely in my room.**

**\_\_\_\_\_ I understand that for fire and health safety, smoking (or any tobacco consumption such as chew, e-cigs, etc.) is not allowed inside the hotel, including the outside quads, or near any of the entrances. Residents will be allowed to take breaks according to the Break Schedule posted in the rooms, during which smoking is allowed.**

\_\_\_**\_\_ I understand that, if I face a medical emergency, staff will call 911 to access medical assistance for me at my expense. I further understand that staff will share the “emergency information” I provided at intake with the responding emergency personal. This includes paramedics, fire responders, law enforcement, and any other emergency personnel.**

 **I consent to staff contacting the emergency contact I provided at intake. I may revoke this authorization at any time by submitting a request in writing to the Senior Program Manager. Staff will only discuss with my emergency contact information that pertains to the emergency.**

**\_\_\_\_\_ I understand that the staff and volunteers of Abode Services are not responsible for any of my items or belongings that are lost, stolen, or damaged. I have been advised not to keep valuable items or large amounts of money with me at the hotel.**

**\_\_\_\_\_ I understand that theft is not tolerated and may result in my being asked to leave the program.**

 **I understand that the furniture provided in my room are placed in accordance with fire safety regulations. I agree not to move, remove, or add furniture to my room.**

**\_\_\_\_\_ I understand that hotel staff will not be cleaning my room during my stay and that it is my responsibility to place my bedding and towels in a plastic garbage bag outside my door once per week for cleaning. At that time, I will receive clean linens, and I will be responsible for making my bed, cleaning surfaces, and maintaining the cleanliness of my room otherwise. I agree to return all bed linens, pillows, and towels to hotel staff and to leave my room clean when I exit the hotel. I understand that any personal belongings I leave behind will be thrown away.**

**\_\_\_\_\_ I understand that meals will be delivered to my room at 8:00 AM, 12:00 PM, and 6:30 PM and that it is my responsibility to leave my dishes and utensils outside my door for pickup when I am done eating.**

**\_\_\_\_\_ I understand in the event of an emergency, I should walk calmly to an exit, staying at least 6 feet away from all other residents, and evacuate the building as quickly as possible. In case of fire, use the clearly marked designated fire exits. Once everyone has reached the assembly site, everyone must report to staff so they can verify that all residents and staff are accounted for.**

**By my signature below, I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, acknowledge the information presented in this checklist and agree to the statements above. I have had the opportunity to speak with a staff member about any concerns or questions I have regarding this information.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Participant Signature Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Staff Signature Date**



**Date:**

**Resident Name:**

**ISOLATION AGREEMENT**

While staying at this hotel, I am responsible for remaining in isolation. By signing this agreement, I agree to:

\_\_\_\_\_ **Stay in my room.** This includes not going to work, school, or public areas, and not using public transportation, ride shares, or taxis.

\_\_\_\_\_ **Separate myself from other people in the hotel.** I will avoid being around infants less than one year of age, pregnant women, persons whose immune systems are weak, or anyone who works with any of these groups.

\_\_\_\_\_ **Wear a facemask.** If I am out of my room, I will wear a facemask.

\_\_\_\_\_ **Cover my coughs and sneezes.** When I cough or sneeze, I will cover my mouth or nose with a tissue or sneeze into my sleeve. I will not cough or sneeze into my hands. After coughing or sneezing into a tissue, I will throw the tissue away into a lined trash can and immediately wash my hands with soap and water for at least 20 seconds.

\_\_\_\_\_ **Wash my hands often and thoroughly for 20 seconds with soap and water,** especially after sneezing or coughing, blowing my nose, going to the bathroom, or having contact with moist materials like tissue. I understand that alcohol-based hand sanitizer with a minimum content of 62% alcohol can also be used instead of soap and water, if my hands are not visibly dirty. I will avoid touching my eyes, nose, and mouth with unwashed hands.

\_\_\_\_\_ **Not have visitors at any time.**

\_\_\_\_\_ **Monitor my symptoms.** If my illness gets worse (for instance, if I have difficulty breathing), I will immediately inform staff by calling the Front Desk for assistance. If I am transported by ambulance, I will inform the paramedics that I am under isolation for Coronavirus.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Participant Signature Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Staff Signature Date**

**Intake Check List**

**Office Use Only**

Participant must sign the following upon entrance:

* Abode Additional Information Form \_\_\_\_
* Authorization to Release Information Form \_\_\_\_
	+ Staff signature \_\_\_\_ Guest signature \_\_\_\_
* Guest Grievance Policy \_\_\_\_
* Guest Agreement \_\_\_\_
	+ Staff signature \_\_\_\_ Guest signature \_\_\_\_
* Isolation Agreement
	+ Staff signature \_\_\_\_ Guest signature \_\_\_\_

Staff must make a copy of any of the following that guest has (not required):

* Guest’s Driver’s license \_\_\_\_\_
* Social Security Card \_\_\_\_

Staff must verbally review the following with the client

* Guest Agreement \_\_\_\_\_
* Grievance Policy \_\_\_\_\_

Staff must provide the Guest with the following:

* Orientation to facility and explanation of how to get assistance \_\_\_\_\_
* Copy of the signed Guest Agreement \_\_\_\_\_
* Copy of signed Grievance Policy \_\_\_\_\_
* Copies of any other intake documents that they request \_\_\_\_\_