Wallace H. Johnson Group Home
Referral checklist

Client Name:_____ Referral Date:_____

Referral Source:_____ & phone number:_____

_____ Admission Form

_____ Group Home Rules Policy and Procedure form

_____ Voluntary Admission Statement

_____ Complete & recent psychosocial assessment

_____ Statement from physician that prospective client is medically and mentally stable to reside in the group home environment

_____ Current medication list signed off by physician

_____ Letter from prospective client stating how they feel the group home program can help them and what they hope to accomplish by going through the program

_____ Authorization to Disclose Information

_____ TB test results

_____ Client needs to arrive with at least 7 – 10 days worth of current medications, refill prescriptions as well. Client will be referred to a representative of FasPsych for medication management at Yellowstone Behavioral Health Center.

FOR OFFICE USE ONLY

_____ Telephone Interview with Client / date _____

_____ Proof of income

_____ Copy of insurance or Medicaid card

_____ Notify Nurse of client's arrival / Med Management appointment _____

Individual determined not appropriate for services due to: _____
_____

Individual was referred to: _____

Notes: _____
_____
_____

GROUP HOME ADMISSION

It is the policy of the Wallace H. Johnson Group Home to admit persons with mental illness who have the ability to benefit from the services provided. This facility is a 24-hour a day, 7 day a week therapeutic facility aimed at providing clients the opportunity to learn and practice daily living skills to become independent within the community while improving their emotional stability. The maximum length of stay is 90 days.

ADMISSION CRITERIA:

1. Mental illness diagnosis
2. Medically stable, must be able to exit the building within 3 minutes in case of fire
3. Not suicidal, homicidal, or physically aggressive
4. Must agree to remain alcohol and illegal drug free while at group home
5. Must not be intoxicated for a minimum of 72 hours prior to signing agreement with referring agency to voluntary admission to Group Home
6. Must be 18 years or older
7. Must not require 24 hour nursing supervision
8. Must agree to abide by the rules of the Group Home and the laws of the State of Wyoming
9. Must agree to participate fully in all aspects of the program including: compliance with treatment team recommendations, psychiatric professional's recommendations, medication regime, primary care physician's orders, discharge plans, and referring agency requirements
10. Must have ability to learn skills to become independent in a minimum of 90 days
11. Determined an appropriate referral by the Group Home Treatment Team

Persons shall be considered for admission without regard to race, color, sex or sexual orientation, religion, creed, national origin, age (except under 18 years), familial status, marital status, source of income, or disability in addition to the mental illness.

Priority for admission is given to residents of the Northwest Region – Park, Big Horn, Washakie, and Hot Springs Counties. Residents outside this region may be accepted depending on bed availability. Referral is made utilizing the referral checklist of necessary forms and paperwork (see forms).

The Group Home is a voluntary program and clients who enter the program must agree to stay until the Treatment Team recommends discharge.

ADMISSION SCREENING:

Prior to accepting a resident for admission to the program, the Group Home Treatment Team will determine if the client meets admission criteria. The prospective client will receive an explanation of the program, be given a copy of the Group Home Rules, and be offered the opportunity to visit Group Home prior to admission.

ADMISSION ORIENTATION:

Upon admission, a Group Home staff person shall provide an orientation to each new resident that includes: a tour of Group Home, introduction to other staff and clients who use the Group Home, discussion of house rules, explanation of the laundry and food service schedule, review of resident rights and grievance procedures, discussion of the conditions under which residency would be terminated, and a general description of available services and activities. Orientation shall also include an explanation of fire and safety procedures.

Admission Form
Wallace H. Johnson Group Home

Name: _____ **Today's Date:** _____

Name of person completing form: _____ **Relationship to client:** _____

Address: _____
Street City Zip County

Client's home phone: _____ **Client's work phone:** _____

Date of Birth: _____ **Age:** _____ **Gender:** _____ **SS#:** _____

Race: ☐ White ☐Black ☐Native American ☐Hispanic ☐Asian ☐Pacific Islander ☐Other ☐More than one race

Religion: _____ **Veteran: Yes/No** **Active Duty: Yes/No Military ID#** _____

Employer: _____ **Employer's phone #:** _____

Education: Please indicate the highest grade completed, 00 – 24 _____ **(completed H.S. – 12)**

Name of Referring Agency: _____

Name of Current Therapist: _____

Name of Case Manager: _____

Emergency Contact: _____
Name Contact # Relationship

Current Diagnosis:

_____

_____

_____

_____

_____

_____

List current medication(s) and dosage(s):

_____

_____

_____

_____

_____

_____

Psycho-social information attached: □ Yes □ No

Medically stable report attached: □ Yes □ No (must include pregnancy determination for females)

Name of Physician: Dr._____ Ph**one #:** _____

Name of Psychiatrist: Dr._____ **Phone #:** _____

Does client have history of substance abuse: □ Yes □ No If so, please explain:

_____

_____

Does client have history of suicide, homicide or violence: □ Yes □ No If so, please explain:

_____

_____

Family Involvement: _____

Spouse/Partner Contact #

_____

Parent/Grandparent Contact #

_____

Child Contact #

_____

Child Contact #

Payment Source for medical needs and/or medications:

□ Self Pay (please provide proof of income for all clients)

□ Medicaid #_____

□ Insurance Provider _____
Group # _____
Policy Holder _____

Funding Source if different from list above: _____

Person completing this form: _____ Date: _____

Signature

_____

Print Name

If person completing this form is not client:

_____Date: _____

Client's signature

YELLOWSTONE BEHAVIORAL HEALTH CENTER

Offering Hope for a Better Tomorrow

I _____, acknowledge that if I leave my belongings at Wallace H. Johnson Group Home they become the property of the Group Home and will be disposed of as staff deems necessary.

Signed_____ Dated_____

Witnessed_____ Dated_____

Wallace H. Johnson Group Home, 2713 Cougar Avenue, Cody, Wyoming 82414 (307) 587-5112 fax (307)587-5446
Powell Office, 627 Wyoming Avenue Powell, Wyoming 82435 (307) 754-5687 (fax 307/754-5697)
Cody Office, 2538 Big Horn Avenue, Cody, Wyoming 82414-9299 (307) 587-2197 (fax 307/527-6218)
(800) 949-8839

YELLOWSTONE BEHAVIORAL HEALTH CENTER
Offering Hope for a Better Tomorrow

Wallace H. Johnson Group Home
RELEASE FORM

Participant's Name: _____
(please print)

I, _____, (□ as a participant or □ as legal guardian to a participant) of the Wallace H. Johnson Group Home recognize that there can be inherent risk by being attendant in any physical activity within the Wallace H. Johnson Group Home and program sponsored trips away from the house.

I agree to hold Yellowstone Behavioral Health Center and its agents harmless for any injuries incurred during the normal course of activities in the Wallace H. Johnson Group Home.

I hereby consent and agree that any photographs, films, video recordings, and/or audio recordings of myself. may be used in:

____ Scrap books and or framed photographs within the group home; which may revel that I have been in the group home and may be seen by future group home participates and visitors to the group home.

____ For grants written by Yellowstone Behavioral Health Center or presentations done by Yellowstone Behavioral Health Center to help in acquiring funds for program support.

____ I waive any and all claims for compensation or royalties for such use and am not opposed to media coverage of my involvement with Yellowstone Behavioral Health Center.

This release will remain in effect until such time that the participant is no longer enrolled in the program

_____ _____
Signature of Participant Date

_____ _____
Signature of Legal Guardian Date

_____ _____
Witness Date

Dec-12

GROUP HOME RULES POLICY AND PROCEDURE:

Policy: It is the policy of the Wallace H. Johnson group home to establish rules for the group home that support the rights of the client while protecting their health and well being. The rules provide for their safety and the safety of others, enhance growth and security and develop their ability to interact with others appropriately.

Procedure:

Group Home Rules:

1. Remain clean and sober. Abstain from the use of alcohol and illegal drugs at all times. No over-the-counter meds without physician approval.
2. Treat yourself and others with respect and kindness.
3. Follow the directions of your psychiatrist, nurse, and physician
4. Actively participate in your treatment plan
5. Follow the directions of the group home staff
6. Comply with your medication regime
7. Be honest with yourself and others
8. Keep yourself, your room, and your belongings clean and neat.
9. Do not leave the group home without authorization
10. Learn daily living skills by doing chores at the group home.
11. Participate in the group home program.
12. Smoking outside only
13. No electronics except a personal cell phone and/or Ipod will be allowed at the Group Home. The Group Home is not liable if your personal electronics are lost or stolen while you have them at the Group Home.
14. Participants will not be allowed to watch movies that are rated R or X.

The following actions will be grounds for discharge:

1. Use of alcohol or illegal drugs.
2. Violence or threats of violence toward others
3. Destruction of property
4. Violation of the Wyoming law
5. Refusal to comply with treatment
6. Refusal to follow rules of group home
7. Abuse of self or others

Client Signature: _____ Date: _____

Witness: _____ Date: _____
(Name and Title)

YELLOWSTONE BEHAVIORAL HEALTH CENTER

Offering Hope for a Better Tomorrow

Date: _____

Client: _____ Date of Birth: _____

To Whom It May Concern:

_____ is cleared to participate in a residential behavioral health program. The client's condition is stable and they are able participate in normal physical activities such as exercise videos and walking.

Signature of Medical Provider: _____

Printed Name of Medical Provider: _____

Address: _____

Phone: _____

OVER-THE-COUNTER MEDICATIONS PHYSICIANS ORDERS

YELLOWSTONE BEHAVIORAL HEALTH CENTER

WALLACE H. JOHNSON GROUP HOME

Client Name: _____ **Allergies:** _____

DOB: _____ _____

Medication	Indications (Dosage, Signs, & Symptoms)	May Be Administered
Generic Substitutes	MAY BE UTILIZED	**Yes** **No**
Tylenol (acetaminophen)	**Signs & Symptoms:** For pain or fever >_____° F **Dosage:** (325 mg) 1 Tab every 4 hours for mild pain; 2 Tabs for moderate pain; not to exceed 8 tabs in a 24-hour period.	**Yes** **No**
Tylenol (acetaminophen)	**Signs & Symptoms:** For pain or fever >_____° F **Dosage:** (500 mg) 1 Tab every 4 hours for mild pain; 2 Tabs for moderate pain; not to exceed 8 tabs in a 24-hour period.	**Yes** **No**
Motrin (ibuprofen)	**Signs & Symptoms:** For musculoskeletal pain or fever >_____° F **Dosage:** (200 mg) 1 tab every 4 hours for mild pain; 2 tabs for moderate pain; not to exceed 8 tabs in a 24-hour period.	**Yes** **No**
Aleve (naproxen)	**Signs & Symptoms:** For musculoskeletal pain or fever >_____° F **Dosage:** (220 mg) 1 tab every 8-12 hours. For the first dose you make take 2 tabs within the first hour. Do not exceed 2 tabs in any 8-12 hour period. Do not exceed 3 tabs in a 24-hour period.	**Yes** **No**
Tums Ultra Strength (calcium carbonate)	**Signs & Symptoms:** For acid indigestion **Dosage:** (1000 mg) Chew 2-3 tabs as symptoms occur. Do not take more than 7 tablets in a 24-hour period.	**Yes** **No**
Gas-X Extra Strength (simethicone)	**Signs & Symptoms:** For bloating, pressure, or fullness **Dosage:** (125 mg) 1-2 softgels by mouth with water as needed after meals or at bedtime. Do not exceed 4 softgels in a 24-hour period.	**Yes** **No**
Imodium A-D (loperamide HCl)	**Signs & Symptoms:** For diarrhea **Dosage:** (2 mg) 2 softgels after the first stool; 1 softgel after each subsequent loose stool, but no more than 4 softgels in a 24-hour period.	**Yes** **No**
Colace (docusate sodium)	**Signs & Symptoms:** For constipation **Dosage:** (100 mg) Take 1-3 softgels by mouth daily. Doses may be taken in a single daily dose or in divided doses.	**Yes** **No**
Milk of Magnesia (magnesium hydroxide)	**Signs & Symptoms:** For constipation **Dosage:** (1200 mg in each 15 mL Tablespoon) 2-4 Tablespoonfuls once a day a bedtime. Drink a full glass of liquid with each dose.	**Yes** **No**
Neosporin Triple Antibiotic Ointment (bacitracin, neomycin, polymyxin)	**Signs & Symptoms:** For treatment of minor cuts, scrapes, & burns. **Dosage:** (400 units/3.5 mg/5,000 units) Apply a small amount topically to wound (after thorough cleaning); not to exceed 3 times in a 24-hour period.	**Yes** **No**
Bacitracin Ointment	**Signs & Symptoms:** For treatment of minor cuts, scrapes, & burns. **Dosage:** (500 units) Apply a small amount topically to wound (after thorough cleaning); not to exceed 3 times in a 24-hour period.	**Yes** **No**
Benadryl (diphenhydramine)	**Signs & Symptoms:** For allergy symptoms **Dosage:** (25 mg) 1 tab every 4 hours for mild symptoms; 2 tabs for moderate symptoms; not to exceed 8 tabs in a 24-hour period.	**Yes** **No**
Centrum (Multi Vitamin)	**Signs & Symptoms:** For dietary supplement. **Dosage:** 1 tab daily	**Yes** **No**
Ocean Saline Nasal Spray (saline nasal spray)	**Signs & Symptoms:** For nasal dryness from allergies, colds, flu, rhinitis, and sinusitis **Dosage:** Squeeze bottle twice in each nostril as often as needed	**Yes** **No**

Physician/Healthcare Provider Signature: _____ Date/Time: _____`

YELLOWSTONE BEHAVIORAL HEALTH CENTER

Offering Hope for a Better Tomorrow

To Whom It May Concern;

_____ is a client in the Wallace H. Johnson Group Home. According to policy and procedure we are required to have a list of each person's current prescription medication and dosage; in addition we need physician's approval to administer over the counter medications. Please list this patient's current prescription medications, dosage, times per day and any additional instructions in the provided space. Please feel free to copy this as many times as necessary to include all medications taken by this individual.

Medication	Dosage	Times per day	Additional information

Please check any over the counter medications that may be used by this individual **at the recommended dosage**. *If needed at different dosages please indicate on the provided line.*

□ Ibuprofen _____
□ Acetaminophen _____
□ Calcium Carbonate (Antacid) _____
□ Loperamide Hydrochloride (Anti-diarrheal) _____
□ Bismuth Subsalicylate (Upset stomach reliever/Anti-diarrheal) _____
□ Other _____
□ Other _____
□ Other _____

When you have completed this form please fax to Yellowstone Behavioral Health at **587-5446, Attention: Wallace H. Johnson Group Home.** If you have any questions please call us at 587-5112. We would like to thank you in advance for your timely attention to this matter!

_____ _____

Physician's Signature *Date*

Dec-12

Voluntary Admission Statement for the Wallace H. Johnson Group Home:

I_____agree to the following conditions while living at the Wallace H. Johnson Group Home.

1. I will remain free of drug and alcohol use while residing at the group home.
2. I will not take any medications, including over-the-counter, without the written permission of my physician.
3. I will abide by the rules of the group home and the laws of the state of Wyoming.
4. I will fully participate in all aspects of the program including: compliance with my treatment teams' recommendations, treatment plan, psychiatrist's recommendation, medication regime, primary care physicians orders, discharge plan, and referring agency requirements.
5. I will follow the directives of the staff of the group home.

In signing this form I agree to the conditions and I affirm I have been free of the effects of drugs or alcohol for a minimum of 72 hours.

_____ _____-
Name Date

_____ _____
Witness Date

_____ _____
Witness Date