Peninsula Community Health Services
Medical Respite Center
Patient Admission Agreement

Welcome to the Peninsula Community Health Services Medical Respite Center. Our goal is to provide you with a safe and supportive place to recover from your illness or injury. During your time here, we hope to help you improve your overall health and begin working toward better living arrangements.

Your safety, along with that of other patients and our staff, is our top priority. The expectations outlined below are in place to create a healing and secure environment for everyone in our medical respite program. Failure to follow these guidelines may result in dismissal from the program.

I understand that the medical respite program aims to assist me in improving my health by offering a place for me to heal. The staff at the Medical Respite Center will provide medical and emotional support as needed during my stay. The length of my stay will depend on ongoing assessments by my care team. The clinical staff will provide me with an estimated duration of stay, which may change based on my progress and their evaluations. I agree to the following terms and conditions described below:

Admission Requirements

1. I attest that I am currently experiencing homelessness.
2. I understand that the medical respite program is for individuals dealing with medical and behavioral health issues.
3. I understand and agree that my belongings will be inspected for weapons and treated for bedbugs upon admission; refusal may affect admission.
4. I understand and agree that firearms, knives, and other sharps and weapons found during inspection will be stored securely and returned at discharge or turned over to authorities.
5. I understand that I must sign a release of information if receiving methadone maintenance therapy to coordinate care.

Daily Care and Treatment Participation

6. I agree to receive daily care from the medical respite clinical team as deemed appropriate by PCHS.
7. I understand that I must be available on-site during business hours for scheduled meetings with the medical respite staff.
8. I agree to attend medical appointments and follow my treatment plan as directed.
9. I understand that treatment plans are confidential and tailored to individual needs.
10. I understand that staff may require that I meet with the behavioral health team if they believe it will help with my treatment; refusal may result in discharge.

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Behavior and Conduct

11. I will respect the rights of other patients and staff, including maintaining personal hygiene and refraining from engaging in disruptive behavior.
12. I understand that I am not allowed to enter other patients' rooms.
13. I understand that smoking is allowed only in designated rooftop areas after hours.
14. I understand that physical contact between patients is prohibited.
15. I understand that drug use, possession, or sale, including drug paraphernalia and alcohol, is prohibited; violation may lead to discharge.
16. I understand and agree that I may be asked to provide a urine sample for drug testing if concerns arise.
17. I understand I am not allowed to engage in any illegal activities.
18. I understand that no money exchanges are permitted on-site.
19. I understand that personal food is allowed but must be properly stored.
20. I understand and agree that personal belongings are limited to one container; unclaimed items will be discarded.
21. I understand that bicycles are not allowed inside the units.

Visitor and Curfew Policies

22. Visitors are allowed between 10:00 a.m. and 2:00 p.m. on weekdays only; no visitors in patient or staff rooms; no visits on weekends.
23. Patients of the Medical Respite Center may come and go freely each day before 8:00 p.m.
24. Curfew is from 8:00 p.m. to 7:30 a.m. daily; absence for three (3) consecutive days may result in discharge.
25. We ask that patients refrain from contacting 911 or emergency services for non-emergent situations. If you do need emergency services, it may be necessary for us to discharge you from the medical respite program to ensure that you can receive a higher level of care that meets your emergent needs.

Room and Facility Policies

26. I understand and agree that I may be asked to move rooms, if necessary.
27. I understand and agree that my personal items must always remain within my assigned room.
28. I understand that I am not allowed to enter other patients' rooms.

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Discharge Policies

29. I understand that the maximum duration of stay at the Medical Respite Center is thirty (30) days, and the length of my stay will be determined by PCHS staff.
30. I understand that I will receive at least 12 hours' notice of discharge, except in cases of policy violation.
31. I understand and agree that immediate discharge may occur for inappropriate, violent, or aggressive behavior.

Violation of these terms may lead to termination from the program and discharge from the Medical Respite Center. Please ask a staff member if you have questions or concerns.

I have read and understand the Medical Respite Patient Admission Agreement. My signature below indicates agreement to these terms.

Medical Respite Patient Signature:

_____ _____

Respite Patient Printed Name Date

_____

Respite Patient Signature

Medical Respite Program Staff:

_____ _____

Printed Name Date

_____

Signature

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