Bob Tavani House
Medical Respite

To Whom It May Concern:

Thank you for considering Bob Tavani House for Medical Respite (BTH).

At BTH, our mission is to provide a supportive home environment while fostering connections to the community for individuals who have an immediate medical need and lack safe housing.

We offer guests a safe and comfortable place to heal, with private rooms and nutritious meals to support their recovery. Our program includes transportation assistance, connections to community resources for a smooth transition out of care, and part-time nursing services to monitor and address medical needs.

Eligibility for Admission:

- Age 21 or older
- Has or is willing to establish a Primary Care Provider (PCP) in Duluth
- Independent with medications and activities of daily living (ADLs)
- Able to safely navigate stairs independently
- Does not require inpatient drug or alcohol treatment (early remission may be considered)
- Psychiatrically stable and able to live with live-in volunteers
- Agrees to follow program rules and participate in their own care
- Is not required to register as a sexual offender

Referral and Admission Process:

1. Case workers or potential guests contact BTH at (218) 206-0609 or referral@bthrespite.org with patient information to check availability.
2. If a room is available, BTH staff provide directions for obtaining a medical referral: ○
   Hospital Inpatient: DFMC residents screen patients and send inter-agency referral to referral@bthrespite.org if appropriate.
   ○ **Emergency Department**: Case workers submit referrals with clinical documentation demonstrating the need for medical respite care.
   ○ **Community**: PCP submits completed referral forms to referral@bthrespite.org or the forms may be hand delivered if preferred. (BTH staff can help establish care at DFMC if needed).
3. BTH staff screen patients within 24–48 hours and communicate decisions to case workers.
4. Accepted patients are transported to BTH by staff or voucher.

For questions, please contact us at **(218) 206-0609** or **referral@bthrespite.org**.

Sincerely,
Bob Tavani House for Medical Respite Staff

2119 West 2nd Street, Duluth, Minnesota 55806
(218) 206-0609 �� info@bthrespite.org

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Medical Respite

The patient may fill out this page. Provider, please review and sign.

Demographics			
First Name		Last Name	
Date Of Birth		Sex	
Preferred Name		Gender/Pronouns	
Phone #		Race/Ethnicity	
Insurance Type		Insurance ID #	
Emergency Contact Name		Emergency Contact #	
Emergency Contact Relation		Cultural Considerations	

Allergies (medications, food, environmental, etc)

Providers	
Primary Care Provider	Location / Contact Info
Psychiatry Provider	Location / Contact Info
Therapist	Location / Contact Info
Case Manager	Location / Contact Info

Current Medications

Reviewed by provider

____ Provider Name Provider Signature

_____ _____ Date

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Please fill out this page based on your conversation with the patient.

Medical Condition			
Current medical necessity for respite care? (Please describe why this person requires medical respite, may include anticipated time for recovery)			
Patient is 21 years or older?	Yes No	Patient is willing to sign agreements to follow program rules and participate in own care:	Yes No
Patient has a local primary care provider?	Yes No		
Patient is homeless or at risk of homelessness?	Yes No	Patient is actively using illicit substances	Yes No
Patient is capable of navigating 15 stairs independently?	Yes No	Is the patient willing and able to seek sobriety at this time?	Yes No
Patient is psychologically stable and able to live alone and with live-in volunteers?	Yes No	Patient has a history of violence or aggression	Yes No
Patient has potential for improvement and discharge from BTH in 21 days?	Yes No	Does the patient qualify for short-term rehab, long-term care, or acute rehab?	Yes No
Patient requires less than minimal assistance with ADL's	Yes No	Patient is a registered sex offender	Yes No

Referring provider please sign and date.

____ Provider Name _ Provider Signature

_____ Date

_____

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Instructions for Minnesota Standard Consent Form to Release Health Information

Important: Please read all instructions and information before completing and signing the form.

An incomplete form might not be accepted. Please follow the directions carefully. If you have any questions about the release of your health information or this form, please contact the organization you will list in section 3.

This standard form was developed by the Minnesota Department of Health as required by the Minnesota Health Records Act of 2007, Minnesota Statutes, section 144.292, subdivision 8. The form must be accepted by a Minnesota provider as a legally enforceable request under the Minnesota Health Records Act. If completed properly, this form must be accepted by the health care organization(s), specific health care facility(ies), or specific professional(s) identified in section 3.

A fee may be charged for the release of the health information.

The following are instructions for each section. Please type or print as clearly and completely as possible.

1 Include your full and complete name. If you have a suffix after your last name (Sr., Jr., III), please provide it in the "last name" blank with your last name. If you used a previous name(s), please include that information. If you know your medical record or patient identification number, please include that information. All these items are used to identify your health information and to make certain that only your information is sent.

2 If there are questions about how this form was filled out, this section gives the organization that will provide the health information permission to speak to the person listed in this section. **Completing this section is optional.**

3 In this section, state who is sending your health information.

Please be as specific as possible. If you want to limit what is sent, you can name a specific facility, for example Main Street Clinic. Or name a specific professional, for example chiropractor John Jones. Please use the specific lines. Providing location information may help make your request more clear. Please print "All my health care providers" in this section if you want health information from all of your health care providers to be released.

4 Indicate where you would like the requested health information sent. It is best to provide a complete mailing address as not everyone will fax health information. A place has been provided to indicate a deadline for providing the health information. Providing a date is optional.

5 5 Indicate what health information you want sent. If you want to limit the health information that is sent to a particular date(s) or year(s), indicate that on the line provided.

For your protection, it is recommended that you initial instead of check the requested categories of health information. This helps prevent others from changing your form.

EXAMPLE: All health information

If you select **all health information**, this will include any information about you related to mental health evaluation and treatment, concerns about drug and/or alcohol use, HIV/ AIDS testing and treatment, sexually transmitted diseases and genetic information.

Important: There are certain types of health information that require special consent by law.

Chemical dependency program information comes from a program or provider that specifically assesses and treats alcohol or drug addictions and receives federal funding. This type of health information is different from notes about a conversation with your physician or therapist about alcohol or drug use. To have this type of health information sent, mark or initial on the line at the bottom of page 1.

Psychotherapy notes are kept by your psychiatrist, psychologist or other mental health professional in a separate filing system in their office and not with your other health information. **For the release of psychotherapy notes, you must complete a separate form noting only that category. You must also name the professional who will release the psychotherapy notes in section 3.**

6 Health information includes both written and oral information. If you do not want to give permission for persons in section 3 to talk with persons in section 4 about your health information, you need to indicate that in this section.

7 Please indicate the reason for releasing the health information. If you indicate marketing, please contact the organization in section 4 to determine if payment or compensation is involved. If payment or compensation to the organization is involved, indicate the amount.

8 This consent will expire one year from the date of your signature, unless you indicate a different date or event.

Examples of an event are: “60 days after I leave the hospital,” or “once the health information is sent.”

9 Please sign and date this form. If you are a legally authorized representative of the patient, please sign, date and indicate your relationship to the patient. You may be asked to provide documents showing that you are the patient or the patient’s legally authorized representative.

This form was approved by the Commissioner of the Minnesota Department of Health on January 30, 2008 and updated in Feb. 2024 Feb. 2024

Minnesota Standard Consent Form to Release Health Information

1.

Patient Information

First name Middle name Last name Patient date of birth Previous name(s) ~~MM-DD-YYYY~~

Home address

City State Zip code Daytime phone Email address (optional)

Medical Record/patient ID number (optional)

2. Contact for information about how this form was filled out (optional)

I give permission for the organization(s) listed in section 3 permission to talk to

First name Last name about how this form was completed.

This person can be reached at: Daytime phone Email address (optional)

3. I am requesting health information be released from at least one of the following:

Organization(s) name

Specific health care facility or location(s)

Specific health care professional’s name(s)

4. I am requesting that health information be sent to:

Organization(s) name

And/or person: First name Last name

Mailing address

City State Zip code Phone (optional) Fax (optional)

Information needed by (date) ~~MM-DD-YYYY~~(optional)

5. Information to be released

IMPORTANT: indicate only the information that you are authorizing to be released.

Specific dates/years of treatment

All health information *(see description in instructions for what is included)*

OR to only release specific portions of your health information, indicate the categories to be released:

History/Physical
Laboratory report
Emergency room report
Surgical report
Medications
Other information or instructions

Mental health
Discharge summary Progress notes
Care plan

Immunizations
HIV/AIDS testing
Radiology report
Radiology image(s)

Photographs, video, digital or other images Billing records

The following information requires special consent by law. Even if you indicate **all health information,** you must specifically request the following information in order for it to be released:

Chemical dependency program *(see definition in instructions)*

Psychotherapy notes *(this consent cannot be combined with any other; see instructions)*

This form was approved by the Commissioner of the Minnesota Department of Health on January 30, 2008 and updated in August 2015 Feb. 2024

6. Health information includes written and oral information

By indicating any of the categories in section 5, you are giving permission for written information to be released and for a person in section 3 to talk to a person in section 4 about your health information.

If you do not want to give your permission for a person in section 3 to talk to a person in section 4 about your health information, indicate that here (check mark or initials)

7. Reasons for releasing information

Patient's request
Review patient's current care
Treatment/continued care
Payment
Insurance application
Legal
Appeal denial of Social Security Disability income or benefits
Marketing purposes (payment or compensation involved? NO YES, amount)
Sale (payment or compensation to entity maintaining the information? Other (please explain) NO YES)

8.

I understand that by signing this form, I am requesting that the health information specified in Section 5 be sent to the third party named in section 4.

I may stop this consent at any time by writing to the organization(s), facility(ies) and/or professional(s) named in section 3.

If the organization, facility or professional named in section 3 has already released health information based on my consent, my request to stop will not work for that health information.

I understand that when the health information specified in section 5 is sent to the third party named in section 4, the information could be re-disclosed by the third party that receives it and may no longer be protected by federal or state privacy laws.

I understand that if the organization named in section 4 is a health care provider they will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the consent form.

If I choose not to sign this form and the organization named in section 4 is an insurance company, my failure to sign will not impact my treatment; I may not be able to get new or different insurance; and/or I may not be able to get insurance payment for my care.

This consent will end one year from the date the form is signed unless I indicate an earlier date or event here:

Date MM-DD-YYYY Or specific event

9. Patient's signature Date MM-DD-YYYY OR legally authorized representative's signature Date MM-DD-YYYY Representative's relationship to patient (parent, guardian, etc.)

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting genetic information of any individual or family member of the individual, except as specifically allowed by this law.

This form was approved by the Commissioner of the Minnesota Department of Health on January 30, 2008 and updated in Feb. 2024 Feb. 2024