

Hello,

My name is Rebecca Longwell, I am the CEO for the Our House of Hope, LLC (OHOH). You are reading this letter/email because you have expressed an interest in admission into our program.

Please follow the steps below so we can have a smooth admission.

1. **Arrangement for payment**. Payment is due before or at the time of admission. Once the client is admitted, we do not offer refunds for the first month.

**Wire**: If you choose to make a direct wire transfer, please let me know and I will call you or send a secure email with our bank information.

**Check**: If you send a check, please make it out to **“Our House of Hope, LLC”.** And send to the following address:

**10592 Fuqua St. A-282, Houston, Texas 77089**

1. **Legal documents**. Although we do not need any original legal documents, we do need copies of the following:
	1. Driver’s License or state issued ID/Picture ID
	2. Social Security card
	3. Insurance card. Medicare/Medicaid card/etc.
2. Past facility, hospitalization or other medical or psychiatric evaluation papers. Our House of Hope, LLC (OHOH) would like to have copies of **any** information we can get about the history of the client. This information helps us with treatment and therapy of the client.
3. **Admission Papers**. Attached are admission papers. Please fill them out and send them back or bring them on admission day.
4. **Express Pay**. Please call or go to Healthy Strides RX we use and make sure to set up Express Pay through them, so we can pick up medications for the client whenever needed.

 **4403 Emancipation St., Houston, Texas 77004 @ 281-888-2235**

1. **Medications**. If you have any medications or prescriptions (current or past) for the client, please bring them.
2. **Personal Items**. Please bring the clients personal items which would include clothes, shoes, radio player, undergarments, and any specialized hygiene or beauty products that they may use. Please refer to the list on our website for additional approved items to bring. Items brought that are not on the approved list will be mailed back at the family expense.

The staff and I look forward to working with you and the residents. If you have any questions, please feel free to call or email me.

Rebecca Longwell, CEO/Director of Operations

Our House of Hope, LLC

832-387-4135



**ADMISSION FORM**

Resident Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Admit Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Statues \_\_\_\_\_Single \_\_\_\_\_Married \_\_\_\_\_\_ Divorced \_\_\_\_\_\_Widowed\_\_\_\_\_\_

D.O.B \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Family Contact (Relation) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Permanent Address of Resident \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Social Security # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DL# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hair Color \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Height \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother’s Maiden Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contacts:

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Billing Party Name (relation): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone#(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**AUTHORIZATION for RELEASE OF INFORMATION FORM**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, give permission to OUR HOUSE OF HOPE, LLC to:

\_\_\_\_\_\_\_\_\_\_ Use the following protected health information, and/or

\_\_\_\_\_\_\_\_\_\_ Disclose the following information to:

Names of Individuals:

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

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

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

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

Information to be disclosed:

\_\_\_\_\_\_\_\_\_\_\_ Medical Records

\_\_\_\_\_\_\_\_\_\_\_ Treatment Records

\_\_\_\_\_\_\_\_\_\_\_ Diagnostic Records

\_\_\_\_\_\_\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, payment or your eligibility for benefits.

You may inspect or copy the protected health information to be used or disclosed under this authorization. For protected health information created as part of a clinical trial, your right to access is suspended until the clinical trial is completed.



**AUTHORIZATION for RELEASE OF INFORMATION FORM**

Finally, you may revoke this authorization in writing at any time by providing written notification to OUR HOUSE OF HOPE administration office. Your notice will not apply to actions taken by the requesting person/entity prior to the date they receive your written request to revoke authorization.

Printed Name of Resident

Signature of Resident

Date

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

Printed Name of Agency Representation

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

Date



 **Our House of Hope, LLC**

**Waiver of Liability Relating to Coronavirus/COVID-19**

The novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. COVID-19 is reported to be extremely contagious. The state of medical knowledge is evolving, but the virus is believed to spread from person-to-person contact and/or by contact with contaminated surfaces and objects, and even possibly in the air. People reportedly can be infected and show no symptoms and therefore spread the disease. The exact methods of spread and contraction are unknown, and there is no known treatment, cure, or vaccine for COVID-19. Evidence has shown that COVID-19 can cause serious and potentially life-threatening illness and even death.

Our House of Hope, LLC cannot prevent you from becoming exposed to, contracting, or spreading COVID-19 while utilizing Our House of Hope, LLC’s services or premises. It is not possible to prevent the presence of the disease. Therefore, if you choose to utilize Our House of Hope, LLC’s services and/or enter onto Our House of Hope, LLC.’s premises you may be exposing yourself to and/or increasing your risk of contracting or spreading COVID-19.

ASSUMPTION OF RISK: I have read and understood the above warning concerning COVID-19. I hereby choose to accept the risk of contracting COVID-19 for myself to utilize Our House of Hope, LLC’s services and enter Our House of Hope, LLC’s premises. These services are of such value to me, that I accept the risk of being exposed to, contracting, and/or spreading COVID-19 to utilize Our House of Hope, LLC’s services and premises in person.

WAIVER OF LAWSUIT/LIABILITY: I hereby forever release and waive my right to sue Our House of Hope, LLC and its owners, officers, directors, managers, officials, trustees, agents, employees, or other representatives in connection with exposure, infection, and/or spread of COVID-19 related to utilizing Our House of Hope, LLC’s services and premises. I understand that this waiver means I give up my right to bring any claims including for personal injuries, death, disease or property losses, or any other loss, including but not limited to claims of negligence and give up any claim I may have to seek damages, whether known or unknown, foreseen or unforeseen.

CHOICE OF LAW: I understand and agree that the law of the State of Texas will apply to this contract.

I HAVE CAREFULLY READ AND FULLY UNDERSTAND ALL PROVISIONS OF THIS RELEASE, AND FREELY AND KNOWINGLY ASSUME THE RISK AND WAIVE MY RIGHTS CONCERNING LIABILITY AS DESCRIBED ABOVE:

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I am the legal guardian of the person named above. I have the legal right to consent to and, by signing below, I hereby do consent to the terms and conditions of this Release.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**AUTHORIZATION TO TRANSPORT**

Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, give permission to be transported to/from activities by Our House of Hope (OHOH). This authorization is in effect for the time services are provided. OHOH and staff will exercise his/her best judgment and observe normal precautions. Nevertheless, unforeseeable situations may arise that require a client to be treated medically where OHOH and staff will attempt to gain permission via emergency contact before making any decisions. In the event we are unable to reach the emergency contact, we ask for permission to seek medical care on behalf of the client.

I understand and agree to release Our House of Hope, LLC from liability resulting from any vehicle incidents or if emergency medical treatment becomes necessary for the welfare of the client.

Consent for Emergency Medical Care: Yes No

1. In case of a medical emergency, I hereby authorize NSBH to obtain emergency medical care on my behalf. A medical emergency is defined as:
2. Immediate services required for the alleviation of pain.
3. Immediate diagnosis and treatment of unforeseeable medical conditions are required, if such condition would lead to serious disability or death if not immediately diagnosed and treated.

Client signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/guardian signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thank you,

Rebecca Longwell, Executive Director



**VISITOR POLICY OF OUR HOUSE OF HOPE, LLC**

All visitors MUST sign in upon arrival. It is requested that all visitors call ahead to ensure availability and to prevent disruption of the residents’ schedule in daily programming. When the visit is over, the visitor MUST sign out.

There are two sets of policies regarding visitation at Our House of Hope, LLC: General Policies and Policy based on level.

**The GENERAL POLICIES are as follows:**

For NEW ADMITS, family may **Not** visit during the **first 30 days of admission**. After the first 30 days and upon determination by the clinical team and readiness of the client, all visits are restricted to **Wednesday evenings from 4 pm to 8 pm and Sundays from 10:00 a.m. to 8:00 p.m. for approximately 2 hours or less.**

On Sundays, residents will be allowed to leave campus with visitors with prior clinical approval. Clinical approval **will not be given for off campus visitation for the first 30 days during the assessment/restriction period.** Each case will be determined on an individual basis by the clinical team and based on the needs assessment of the resident.

No visitors are allowed outside of these times except for July 4th, Thanksgiving and Christmas day and the visiting hours for those days are 10:00 a.m. to 8:00 p.m. All other holidays’ visiting hours are restricted to 4:00 p.m. to 8:00 p.m. No visitors are allowed to visit the private rooms of residents at no time.

Please note that when visitors sign in, they will be asked about any electronics, food or other gifts that are being brought for the residents.

**The POLICY BASED ON LEVEL are as follows:**

Our House of Hope has an open-campus policy which means we do not lock individuals in on our campus. New residents have restrictions for the first 30 days and are not permitted to leave campus without a designated staff escort. After the 30 days of restriction (based on needs assessment of resident) all residents have the freedom to leave campus if they return by curfew, which is 8:00 p.m. There are no visitations of family or friends allowed past the time allotted time stated above. All residents are required to sign-in/out when leaving campus, whether they are leaving with a visitor or not. Any visitors on campus will be able to visit at an allowed designated area. Visitors are also not allowed to eat dinner with residents on campus during dinner time.

Thank you,

Rebecca Longwell