§709.71. Intake and admission.

(a) The project director shall develop a written plan providing for intake and admission which includes, but is not limited to:

(1) Criteria for admission.

Criteria should include age, sex, physical and/or mental conditions, geographic requirements and nature of D/A problem. Any special project limitations should also be noted, e.g., serving the handicapped, psychotic, non-English speaking populations.

(2) Guidelines for completion of residency.

Completion should be viewed from both the project and the client perspectives, including the length of residency, employment, financial independence, substance usage, interpersonal relationships.

(3) Involuntary discharge/termination criteria.

Involuntary discharges (acts of violence, use/misuse of chemicals, etc.) and administrative discharges (AWOL, failure to seek employment, etc.).

(b) Intake procedures shall include documentation of:

(1) Disclosure to the client of criteria for admission, completion and discharge.

Disclosure may be documented in initial activity notes, the consent to residency, or orientation packet.

(2) Client orientation to the project which shall include, but not be limited to a familiarization with:

See b (1) above for acceptable documentation of client orientation.
(i) House rules.

(ii) Hours of operation.

(iii) Fee schedule.

   *Examples – per diem, food stamps, special fees, in-kind work.*

(iv) Services provided.

(3) Basic personal data.

   *Include family, legal, employment/vocational, educational, military, recreational, sexual, and others where appropriate.*

(4) Consent to residency.

   *A consent to residency form should be signed by the client at intake. This consent could be integrated with other forms/procedures, e.g., liability determination, intake and orientation verification, residential/house agreements.*

§709.72. Client records.

(a) There shall be a complete client record on an individual which includes information relative to the client’s involvement with the project. This shall include, but not be limited to, the following:

(1) Consent forms.

(2) Client-related correspondence.

(3) Medication records.

   *All medications being taken by a client whether prescribed by the project’s physician or the client’s private physician should be recorded in the chart indicating the name of the drug, dosage, and frequency of use.*

   *[Note: Where projects act as custodians of a client’s medication, a log should be maintained including: the client name, type of medication, amount, time and date, and staff signature. Refer to section on Medication Control.]*

(4) Referral contact.

   *Record the nature and disposition of referrals made to outside resources.*
(5) Activity notes.

A client's progress and current status in meeting his/her goals or needs during residency. All activity notes should be dated and signed by the individual making the entry.

(b) The project shall develop and maintain client records on standardized project client record forms.

§709.73. Client management services.

The transitional living facilities need not comply with §709.24(a) (relating to treatment/rehabilitation management). The project’s governing body shall instead adopt a written plan for the coordination of residential services which includes, but is not limited to:

(1) Defined target population.

That portion of the general population toward whom facility services are directed.

(2) Written procedures for the management of residential services for clients.

(3) Written procedures for referral outlining cooperation with other service providers.

Include who makes and accepts referrals, and how they are to be documented. Procedures should address incoming as well as outgoing referrals.

§709.74. Physical plant. *RESERVED*

See Chapter 705. Physical Plant Standards