

Criteria for admission to Montgomery House

1. TB test no older than one year. And a physical stating that the client appears free from communicable disease that is no older than 45 days.
2. "Self-Med" Letter listing all medications taken and a MD signature attesting that the client can medicate self.
3. D.A.F no older than 1 year or an old one with new updates
4. Current ISP
5. I.D showing US citizenship, i.e. driver's license, state ID, social security card, passport, etc. A birth certificate is not accepted by the county as legitimate ID.

To get process started, fax a completed residential referral form to 458-6291. A referral can be faxed or emailed to you if you do not have one. **ONLY FAX THE REFERRAL FORM, NOT DAF OR ISP AND OTHER FORMS.** The other forms are brought with client to intake appt.

Forms for Physical, TB and "Self-Med" letters can be requested and faxed or emailed also, but are not required. Medical professionals can use their own forms.

Exclusionary Criteria

1. Active psychosis with little or no insight into illness and symptoms.
2. Immediate history of violence or arson.
3. Sex offender Status.

For more information, call Donna Wilson at 458-6292.

Centerpoint Health

I certify that I have performed a physical examination on

_____ On _____
(Name of Client) (Date)

I found him/her to be free of any communicable diseases and in good general health, expect _____

(Please Specify Above)

I certify that a chest x-ray test was performed on _____ with negative results. (Date)

I certify that a tuberculin test was performed on _____ with negative results. (Date)

(Date)

(Signature)

(Name if Physician typed)

(Address)

(Phone Number)

Please return this form to:
Centerpoint Health Montgomery House
6471 Montgomery Road
Cincinnati, Ohio 45213
(513) 458-6292
Fax (513) 458-6291

Montgomery House 458-6292 –Fax 458-6291
Resident Referral Form

Case Managers Name: _____ Date: _____
Agency: _____ Supervisor: _____
C.M. Phone: _____ Sup. Phone: _____
C.M. email: _____ Agency Fax: _____

Client's Name _____ Age _____
Diagnosis _____
Substance Abuse History _____

Criminal Background _____

History of Violence _____

Has client ever been in Norcen Halfway house or Montgomery House _____

Current Living Situation _____
Hamilton County Address _____

Circle Which Identification Number Given

Client Social Security, Driver's License, or State I.D. Number _____

Reason(s) for referral to Montgomery House _____

Do Not Write Below This Line _____

Fax ONLY this form to number above, do not fax any other forms, reports or copies

Centerpoint Health
Montgomery House
(513) 458-6292
Fax (513) 458-6291

Statement of Ability to Self-Administer Oral-Medication

Policy Statement:

All residents of the Halfway House are expected to be responsible for the self-administration of oral medications prior to their entering the halfway House program. This prerequisite is designed to select residents who have the greatest chance of moving on to independent living when their stay at the house is completed.

In order to comply with state licensure regulations of group homes the Halfway House must have on file for each of its resident a statement signed by the prescribing its physician verifying the ability to self-administer current medications. Please complete this form for inclusion in the house case record.

_____ has demonstrated to my satisfaction that he/she is capable of self-administering medication and may retain a _____ (number of days) supply of the following medication(s):

Physician's Signature/ Date

Clinical Therapist/Date