# Stone House Farm & Inn

Established 1813. Reimagined 2021.
2 Stonehouse Road Elliottsburg, PA 17024

**Stone House Farm & Inn Referral Form**

**HUBS (100% CPS) Program**

Date: _____/_____/_____
Referring Agency Name: _____
Referring Agency Phone Number: _____
Supports Coordinator Name: _____

**Participant Information**

Name of Individual: _____
Date of Birth: _____
Gender: _____
Address: _____
Phone Number: _____
Residence (check one): ☐ Group Home ☐ Resides with Family/Guardian/Caregiver
☐ Other:_____
Name of Parent/Guardian/Caregiver _____
Address:_____
Phone Number:_____
What is the best time to contact Parent/Guardian/Care Taker?

_____

*How do you think this individual would enjoy attending Stone House Farm & Inn? What are the interests of this individual?*

_____

_____

*What day(s) is this individual interested in attending Stone House Farm & Inn?*
☐Monday ☐Tuesday ☐Wednesday ☐Thursday ☐Friday

Please provide as much information as possible with the referral (check all that apply and are attached to referral. Items with asterisk must be included before participant can start):

☐ Current Physical/TB Test*
☐ ISP*
☐ BSP
☐ Psychological/Psychiatric Evaluation(s)
☐ Lifetime Medical History*
☐ Assessment(s)
☐ List of Medication*
☐ Other documents

Please fax completed forms to *HEMPFIELD BEHAVIORAL HEALTH: 717-221-8006*
or Mail to HEMPFIELD BEHAVIORAL HEALTH 2019 NORTH 2ND ST. HARRISBURG, PA 17102

***For RTF Use Only***

Pre-Admission Interview Date: _____/_____/_____

Date intake documents completed: _____/_____/_____ Received by: _____

Hempfield Behavioral Health
2019 North 2nd Street Harrisburg, PA 17102
717-221-8004 (phone) 717-221-8006 (fax)

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## PARTICIPANT INFORMATION SHEET

☐ Initial ☐ Annual Update ____/____/____

| | |
|---|---|
| Name: | |
| Admission Date: | |
| Date of Birth / Birth Place: | |
| SSN: | |
| Height: | |
| Weight: | |
| Eye Color: | |
| Hair Color: | |
| Race: | |
| Sex: | |
| Language: | |
| Identifying Marks: | |
| Allergies: | |
| Religious Affiliation: | |

## CURRENT MEDICATIONS

| Medication Name | Dosage | Purpose |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Likes/Strengths:

Dislikes/Triggers:

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## PARTICIPANT PHOTO IDENTIFICATION

☐ Initial ☐ Annual Update ____/____/____

Participant Name:

Address:

Phone Number:

Date of Birth:

Allergies:

MCI:

Date of Picture:
(Attach photo)

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## Participant Contact Information Form

☐ Initial ☐ Annual Update ____/____/____

**Participant Name:**

**Contact #1: Emergency Contact**

| | |
|---|---|
| Name: | |
| Address: | |
| Phone Number: | |
| Relationship to Participant: | |
| Can this person consent for emergency medical treatment? | |

**Contact #2:**

| | |
|---|---|
| Name: | |
| Address: | |
| Phone Number: | |
| Relationship to Participant: | |
| Can this person consent for emergency medical treatment? | |

**Contact #3:**

| | |
|---|---|
| Name: | |
| Address: | |
| Phone Number: | |
| Relationship to Participant: | |
| Can this person consent for emergency medical treatment? | |

**Physician:**

| | |
|---|---|
| Name: | |
| Address: | |
| Phone Number: | |

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**Consent to Participate**

Participant Name: _____ DOB:_____

I have been informed and provided a brochure about the services provided by the Stone House Farm at Hempfield Behavioral Health, and consent for the individual named above to participate in the HUBS (100% CPS) Program. I have been made aware of the risks inherent in farm activities including livestock, farm work, outdoor exposure, and tools and machinery.

I am aware that I may terminate participation from Hempfield Behavioral Health (Stone House Farm & Inn) at anytime.

I am aware that Hempfield Behavioral Health agrees to maintain the confidentiality of any information regarding applicants, program participants, or their immediate families which may be obtained through applications, forms, interviews, test reports from public agencies, counselors, or any other sources. Without permission of the applicant, such information shall be divulged only as necessary for the purpose related to the performance or evaluation of the contract and the persons having responsibilities under the contract.

I am aware that Hempfield Behavioral Health also will provide client information to *Case Management Unit or County MHID Services* if that agency has made the referral for treatment. I understand that services for my participation will be billed to a third party.

I am aware that the above named individual in the process of emergency treatment by a health professional and information from Hempfield Behavioral Health is required for emergency treatment, necessary and limited related information to the emergency may be released without my consent.

I am aware that new or previously unreported incidents of sexual or physical abuse will be reported. In addition, any knowledge of potential danger to self or others may result in breach of confidentiality to the appropriate parties.

I have read this consent, had it explained to me, and understand its contents. I ☐ ACCEPT / ☐ REJECT a copy of this consent.

_____ _____
Participant Signature Date

_____ _____
Parent/Guardian Signature and Relationship to Participant (if Participant is unable to sign) Date

_____ _____
Hempfield Behavioral Health Staff Date

_____
HBH Staff print name and credentials

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## Client Rights and Responsibilities

Client Name: _____ DOB: _____

Participants, public, parents, and guardians will be treated with respect and dignity, and may expect all issues that affect their care to be handled in a confidential manner.

Additionally, clients have the right to:

- Choose a Provider of your choice
- Receive impartial access to necessary treatment and/or accommodations, regardless of race, color, religious creed, disability, ancestry, national origin, age, sex, or sources of payment for care
- Considerate, respectful treatment at all times
- Conduct interviews and be examined in surroundings designed to assure reasonable visual and auditory privacy
- Review communications and other records pertaining to their care, including the source of payment for treatment, and to have that information treated as confidential in accordance with the laws
- Obtain complete and current information concerning diagnosis (to the degree known), treatment, and any known prognosis, and to participate in decision-making regarding their treatment planning
- Give informed consent before the start of any procedure or treatment
- Receive information in a medium that they can understand. If a client does not speak or understand the predominant language of the community, they are able to request funds for an interpreter
- Receive materials that describe important information about their care in a format that is easy to understand and easy to read
- A clear process for complaints and comments, with resolution in a timely manner
- Employees will be trained in clients rights during employee orientation
- Any complaints of discrimination may be filed with the U.S. Department of Health and Human Services Office of Civil Rights, The Department of Public Welfare Bureau of Equal Opportunity, EEOC, and/or The Pennsylvania Human Relations Commission:

Department of Public Welfare
Bureau of Equal Opportunity
223 Health & Welfare Building
Harrisburg, PA 17120

PA Human Relations Commission
Harrisburg Regional Office
333 Market St. 8th Fl
Harrisburg, PA 17011

U.S. Department of Health & Human Services
Office for Civil Rights
Suite 372, Public Ledger Bldg.
150 South Independence Mall West
Philadelphia, PA 19106-9111

Equal Employment Opportunity Commission (EEOC)
Philadelphia District Office
801 Market St., Suite 100
Philadelphia, PA 19107-3126

As part of these rights, clients accept certain responsibilities which are outlined below:

- Respectful and courteous treatment of clinical and administrative staff
- Prompt and regular attendance at scheduled appointments

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- Full and complete disclosure of symptoms and changes in symptoms
- Active participation in evaluations and treatment sessions
- Prompt payment for services
- Presentation of accurate insurance and third party information
- Notice of changes in insurance status
- Completion of homework assignments
- Collection of information for treatment and service evaluation
- Use of the grievance procedure for conflict resolution
- Reporting dissatisfaction with any component of treatment and offering suggestions for improvement
- Disclosing other treatments and treatment providers

I have read this consent, have had it explained to me, and I understand its contents.

I ☐ ACCEPT / ☐ REJECT a copy of this consent.

_____ _____

Participant Signature Date

_____ _____

Parent/Guardian Signature and Relationship to Participant Date

_____ _____

Hempfield Behavioral Health Staff Date

_____

HBH Staff print name and credentials

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**Accident Waiver and Release of Liability**

Participant Name: _____ DOB: _____

I assume all of the risks of participating in any and all activities at the Stone House Farm. I understand that there are certain risks associated with farming, working outside and working with live animals.

I verify that I am physically fit and have not been advised to not participate by a qualified medical professional. I verify that there are no health-related reasons or problems which preclude my participation in activities at the Stone House Farm.

I release Hempfield Behavioral Health and its representatives from all liability, to me or my representative for all claims, demands, losses or damages, related to participation in activities at the Stone House Farm.

I have read this consent, had it explained to me, and understand its contents.

I ☐ ACCEPT / ☐ REJECT a copy of this consent.

_____ _____

Participant Signature Date

_____ _____

Parent/Guardian Signature and Relationship to Participant (If Participant is unable to sign) Date

_____ _____

Hempfield Behavioral Health Staff Date

_____

HBH Staff print name and credentials

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# Stone House Farm & Inn

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## Authorization to Photograph

Name of Participant: _____Participant DOB: _____

I consent to let Hempfield Behavioral Health photograph the above mentioned participant.

Hempfield Behavioral Health would like to photograph you for educational and marketing purposes. These images may appear in our printed brochure, publications, website or Facebook.

I agree that Hempfield Behavioral Health has complete ownership of these pictures and may use them for any purpose consistent with the mission of HBH. These uses may include: illustrations, publications, advertisements, and promotional or educational materials. I acknowledge that I will not receive any compensation.

I understand that I am NOT required to be photographed and I am under no obligation to be photographed. I understand that my access to services will NOT be affected by my decision to not be photographed. I may revoke this consent at any time by informing the Program Director and/or contacting the President, Dr. Howard S. Rosen at 717-221-8004. I may contact Dr. Howard S. Rosen, Ph.D. 717-221-8004 at any time with questions or concerns.

I have read this consent, have had it explained to me, and I understand its contents.
I ☐ ACCEPT / ☐ REJECT a copy of this consent.

_____ _____
Participant Signature Date

_____ _____
Parent/Guardian Signature and Relationship to Participant (if Participant is unable to sign) Date

_____ _____
Hempfield Behavioral Health Staff Date

_____
HBH Staff print name and credentials

Hempfield Behavioral Health
2019 North 2nd Street Harrisburg, PA 17102
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# Stone House Farm & Inn

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## Authorization to Videotape

Participant Name:_____ Participant DOB: _____

I consent to let Hempfield Behavioral Health videotape for educational and marketing purposes. These images may appear on our website or Facebook or in educational or marketing presentations.

I agree that Hempfield Behavioral Health has complete ownership of these images and may use them for any purpose consistent with the mission of HBH. These uses may include: illustrations, publications, advertisements, and promotional or educational materials. I acknowledge that I will not receive any compensation.

I understand that I am NOT required to be videotaped and I am under no obligation to be recorded. I understand that my access to services will NOT be affected by my decision to not be videotaped. I may revoke this consent at any time by informing the therapist and/or contacting the President, Dr. Howard S. Rosen at 717-221-8004.

I may contact Dr. Howard S. Rosen, Ph.D. 717-221-8004 at any time with questions or concerns.

I have read this consent, have had it explained to me, and I understand its contents.

I ☐ ACCEPT / ☐ REJECT a copy of this consent.

_____ _____

Participant Signature Date

_____ _____

Parent/Guardian Signature and Relationship to Participant (if Participant is unable to sign) Date

_____ _____

Hempfield Behavioral Health Staff Date

_____

HBH Staff print name and credentials

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## TRANSPORTATION AUTHORIZATION

Participant Name:_____ Participant DOB:_____

I authorize Hempfield Behavioral Health staff to transport the individual listed above in the HBH vans or staff vehicles. I understand that all riders must wear seat belts.

I have read this consent, have had it explained to me, and I understand its contents.

I ☐ ACCEPT / ☐ REJECT a copy of this consent.

_____ _____

Participant Signature Date

_____ _____

Parent/Guardian Signature and Relationship to Participant (if Participant unable to sign) Date

_____ _____

Hempfield Behavioral Health Staff Date

_____

HBH Staff print name and credentials

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2019 North 2nd Street Harrisburg, PA 17102
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# Stone House Farm & Inn

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2 Stonehouse Road Green Park, PA 17024

## PERMISSION FOR MEDICAL SERVICES

Participant Name: _____ Participant DOB: _____

I hereby give permission to Hempfield Behavioral Health to secure all routine medical services or emergency first aid for the above mentioned individual.

I understand that Hempfield Behavioral Health will make every reasonable effort to contact me whenever a condition arises that requires other than routine medical services. However, in the event of an emergency and I cannot be reached within a reasonable time, I give permission to Hempfield Behavioral Health to secure any and all medical services to meet the medical emergency.

In a medical emergency, staff will call 911 to arrange medical transportation via ambulance. Hempfield Behavioral Health does not have control over what hospital or emergency medical center the transportation provider will choose, however, you may specify below your preference which will be communicated on the participant's behalf.

Preferred Hospital or Emergency Center: _____

I have read this consent, have had it explained to me, and I understand its contents.

I ☐ ACCEPT / ☐ REJECT a copy of this consent.

_____ _____

Participant Signature Date

_____ _____

Parent/Guardian Signature and Relationship to Participant (if Participant is unable to sign) Date

_____ _____

Hempfield Behavioral Health Staff Date

_____

HBH Staff print name and credentials

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## PERMISSION FOR OUTINGS

Participant Name: _____ Participant DOB: _____

I give permission for the staff of Hempfield Behavioral Health to take the above mentioned participant on day outings during program hours.

I, _____, do not give permission for the staff of Hempfield Behavioral Health to take the above mentioned participant on day outings during program hours.

I have read this consent, have had it explained to me, and I understand its contents.

I ☐ ACCEPT / ☐ REJECT a copy of this consent.

_____ _____

Participant Signature Date

_____ _____

Parent/Guardian Signature and Relationship to Participant (if Participant is unable to sign) Date

_____ _____

Hempfield Behavioral Health Staff Date

_____

HBH Staff print name and credentials

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# Stone House Farm & Inn

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## Permission for Exchange of Information

I, _____, hereby authorize Hempfield Behavioral Health to release/receive information contained in the record of _____ DOB: _____.

NAME OF AGENCY / PERSON: Group Home: _____

ADDRESS: _____

THE FOLLOWING INFORMATION MAY BE RELEASED / RECEIVED:

- ☐ Family History
- ☐ Treatment / Service Plan
- ☐ Progress Reports
- ☐ Discharge Summaries
- ☐ Individual Support Plan
- ☐ Other:
- ☐ Neurological Reports
- ☐ Physical Exam / Immunizations
- ☐ Attendance Data
- ☐ Individual Education Plan
- ☐ Medical Reports
- ☐ Case Management Intake / Assessment
- ☐ Vocational Skills Assessment
- ☐ Behavior Plan
- ☐ Achievement Tests
- ☐ Psychological / Psychiatric Evals

For the purpose of: _____

Effective Date(s) From: _____ To: _____

I fully understand the nature of this consent and that this authorization shall remain in effect from the date of my signature for a period not exceeding 1 year. However, I may revoke this authorization at any time by written, dated communication to the Executive Director or designee. A photo static copy of this authorization will be considered valid, and all information will be held in strict confidence. I understand that the policy of Hempfield Behavioral Health is to release only that information about a present or former recipient of services, which, in judgment of its personnel, is considered essential to the purpose for which the authorization is requested. It is also a policy of Hempfield Behavioral Health **to release only information generated by them and not other agencies or institutions.**

I ACCEPT ☐ / REJECT ☐ A COPY of this release.

_____ _____
Participant Signature Date

_____ _____
Parent/Legal Guardian and Relationship (if Participant is unable to sign) Date

_____ _____
Witness Signature and Title Date

_____
Witness Print Name and Credentials

---

*To be completed if the recipient of services is physically unable to provide a signature, but has indicated verbally or behaviorally that he/she consents to the release.*

We affirm that _____ was physically unable to provide a signature, understands the nature of this consent, and freely gave his/her verbal or behavioral consent. This authorization shall remain in effect from this date to _____ (1 year hence). However, this may be revoked by verbal or behavioral communication to the Executive Director or his/her designee.

_____ _____
Witness Signature and Relationship Date

Hempfield Behavioral Health
2019 N. 2nd St. Harrisburg, PA 17102
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## Permission for Exchange of Information

I, _____, hereby authorize Hempfield Behavioral Health to release/receive information contained in the record of _____ DOB: _____.

NAME OF AGENCY / PERSON: MHIDD:_____

ADDRESS:_____

THE FOLLOWING INFORMATION MAY BE RELEASED / RECEIVED:

- ☐ Family History
- ☐ Treatment / Service Plan
- ☐ Progress Reports
- ☐ Discharge Summaries
- ☐ Individual Support Plan
- ☐ Other:
- ☐ Neurological Reports
- ☐ Physical Exam / Immunizations
- ☐ Attendance Data
- ☐ Individual Education Plan
- ☐ Medical Reports
- ☐ Case Management Intake / Assessment
- ☐ Vocational Skills Assessment
- ☐ Behavior Plan
- ☐ Achievement Tests
- ☐ Psychological / Psychiatric Evals

For the purpose of: _____

Effective Date(s) From: _____ To: _____

I fully understand the nature of this consent and that this authorization shall remain in effect from the date of my signature for a period not exceeding 1 year. However, I may revoke this authorization at any time by written, dated communication to the Executive Director or designee. A photo static copy of this authorization will be considered valid, and all information will be held in strict confidence. I understand that the policy of Hempfield Behavioral Health is to release only that information about a present or former recipient of services, which, in judgment of its personnel, is considered essential to the purpose for which the authorization is requested. It is also a policy of Hempfield Behavioral Health **to release only information generated by them and not other agencies or institutions.**

I ACCEPT ☐ / REJECT ☐ A COPY of this release.

_____ _____
Participant Signature Date

_____ _____
Parent/Legal Guardian and Relationship (if Participant is unable to sign) Date

_____ _____
Witness Signature and Title Date

_____
Witness Print Name and Credentials

---

*To be completed if the recipient of services is physically unable to provide a signature, but has indicated verbally or behaviorally that he/she consents to the release.*

We affirm that _____ was physically unable to provide a signature, understands the nature of this consent, and freely gave his/her verbal or behavioral consent. This authorization shall remain in effect from this date to _____ (1 year hence). However, this may be revoked by verbal or behavioral communication to the Executive Director or his/her designee.

_____ _____
Witness Signature and Relationship Date

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## ANNUAL PHYSICAL EXAMINATION FORM

**Name:** _____ Date of Exam: _____
**Address:** _____ SSN: _____
_____ DOB: _____

**DIAGNOSES/ SIGNIFICANT HEALTH CONDITIONS:**

_____
_____

**CURRENT MEDICAIONS** *(attach a second page if needed)*:

| Medication Name | Strength | Dose | Frequency | Diagnosis | Prescribing Physician |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**Allergies/Sensitivities:** _____
**Contraindicated Medications**: _____

**IMMUNIZATIONS:**
**Tetanus/Diphtheria** *(every 10 years)*: ___/___/___
**Hepatitis B:** ___/___/___ ___/___/___ ___/___/___
**Flu shot:** ___/___/___ Pneumovax: ___/___/___
**Other** *(specify)*: _____

**TB SCREENING:** *(every 2 years by Mantoux method, if positive initial chest x-ray should be done)*
DATE Given _____ Date read_____ Results_____
Chest X-ray (date) _____ Results _____

**OTHER MEDICAL/ LAB/ DIANOSTIC TESTS:**
**GYN EXAM W/pap** **Date** _____ **Results:** _____
*(Women over age 18)*
**Mammogram:** **Date**_____ **Results:** _____
*(Every 2 year-women ages 40-49, yearly for women 50 and over)*
**Prostate Exam:** **Date** _____ **Results:** _____
*(Digital method-males 40 and over)*
**Hemoccult** **Date** _____ **Results:** _____
**Urinalysis** **Date** _____ **Results:** _____
**CBC/ Differential** **Date** _____ **Results:** _____
**Hepatitis B Screening** **Date** _____ **Results:** _____
**PSA** **Date** _____ **Results:** _____

**Other** *(specify)*_____

**Part Two: GENERAL PHYSICAL EXAMINATION**

Blood Pressure:____/____ Pulse: ____/____ Respirations:____/____ Temp: ____/____ height: ____/____ Weight: ____/____

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**EVALUATION OF SYSTEMS**

| System Name | Normal Findings? | Comments/ Description |
|---|---|---|
| **Eyes** | ☐Yes ☐No | |
| Ears | ☐Yes ☐No | |
| Nose | ☐Yes ☐No | |
| Mouth/ Throat | ☐Yes ☐No | |
| Head/ Face/ Neck | ☐Yes ☐No | |
| Breasts | ☐Yes ☐No | |
| Lungs | ☐Yes ☐No | |
| Cardiovascular | ☐Yes ☐No | |
| Extremities | ☐Yes ☐No | |
| Abdomen | ☐Yes ☐No | |
| Gastrointestinal | ☐Yes ☐No | |
| Endocrine | ☐Yes ☐No | |
| Musculoskeletal | ☐Yes ☐No | |
| Integumentary | ☐Yes ☐No | |
| Renal/ Urinary | ☐Yes ☐No | |
| Reproductive | ☐Yes ☐No | |
| Lymphatic | ☐Yes ☐No | |
| Nervous System | ☐Yes ☐No | |
| VISION SCREEENING | ☐Yes ☐No | Is further evaluation recommended by specialist? ☐Yes ☐No |
| HEARING SCREENING | ☐Yes ☐No | Is further evaluation recommended by specialist? ☐Yes ☐No |

**Additional Comment:**

Lifetime medical history summary reviewed? ☐Yes ☐No

Medication added, changed, or deleted *(from this appointment)*: _____

Special medication considerations or side effects: _____

Recommendations for health maintenance: *(including need for lab work at reg. intervals, exercise, hygiene, weight control, etc.)*

_____

Recommended diet and special instructions: _____

Information pertinent to diagnosis and treatment in case of emergency:

_____

Free of Communicable Diseases? ☐Yes ☐No (if no, list specific precautions to prevent the spread of disease to others)

_____

Limitations or restrictions for activities *(including work day, lifting, standing, and bending)* ☐No ☐Yes *(specify)*:

_____

Change in health status from previous year? ☐No ☐Yes (*specify*):_____

Continuation of same level of care (e.g., ICF, CLA, Other) ☐Yes ☐No (*specify*):_____

Specialty consults recommended? ☐No ☐Yes (*specify*):_____

_____ _____ _____

**Name of Physician *(please print)*** **Physician's Signature** **Date**

**Physician Address:** _____ **Physician Phone:** _____

_____

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