



# Fellowship Housing Opportunities, Inc.

## MEDICATION SUPPORT SERVICES APPLICATION

### Instructions for Case Manager:

1. Fill out and fax this application to 225.0978 ATTN: Outreach Coordinator.
2. The Outreach Coordinator will contact you to set up an Evaluation Interview.
3. Attend Evaluation Interview with applicant at scheduled time.
4. Once approved for the service, "FHO" must be added to Tx plan as FSS-Med Support Services Provider.
5. Psych. medication order listing all self-administered medications and any independent days must be faxed to the above number.
6. Deliver medications to the Fellowship Housing Outreach Coordinator at 11 Chesley Street.
7. Services will begin once the above steps have been completed fully (a minimum of 24 hours is needed before services can begin).

### General Information

Applicant Name: \_\_\_\_\_ Case #: \_\_\_\_\_ Currently Receives Medicaid:  Yes  No

Street Address: \_\_\_\_\_ Apt: \_\_\_\_\_ City: \_\_\_\_\_

Currently on CD:  Yes  No

Psych. Prescriber: \_\_\_\_\_ Phone: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

Medical Prescriber: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_

Guardian Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

### Medication Support Services are deemed medically necessary in order for the applicant to (check all that apply):

- Reduce Symptoms       Maintain Functioning/Independence       Improve Functioning
- Prevent Relapse       Prevent More Restrictive Setting       Provide Needed Advocacy/Linkage
- Other: \_\_\_\_\_

### Describe the goal of the applicant's participation below:

\_\_\_\_\_

\_\_\_\_\_

**Interventions Required:**       Planner Fill\*       AM Med Support \*       PM Support \*

**Preferred Service Location:**       Home       Fellowship House       Community Setting

\* Hours of Service are: 7:30 am – 11:30 am and 6:00 pm – 10:00 pm. Services must occur within these time frames only.

\* Med order changes received by Fellowship Housing after 2:00 pm will not be implemented until the following day.

\* Unless Fellowship Housing is otherwise instructed by the applicant's treatment team, in instances where severe weather is anticipated, the applicant will be permitted to package the appropriate dose(s) for independent ingestion.

**Agreements:**

I, \_\_\_\_\_, understand that I have been referred by my case manager to become a participant in the Medication Support Services program offered by Fellowship Housing. As such, I consent to the following requirements:

1. I will actively participate, through discussion of symptoms, concerns, and successes with regards to medication, during my service time unless contraindicated by a medical condition documented by a physician and made known to Fellowship Housing.
2. I will be available at the agreed upon location during the required timeframe to participate in the program on all days my prescriber has specified I do so (days for which I do not have medication independence).
3. I am required to respect the privacy, person and property of other consumers, visitors and Fellowship Housing staff.

**I consent to these requirements and wish to participate in the Medication Support Services program.**

**I understand the following:**

1. Fellowship Housing will consistently communicate with my Riverbend clinical team regarding my progress and participation, or lack thereof, in the Medication Support Services program.
2. Fellowship Housing does not have any authority to adjust, titrate, increase or decrease my medications or independence and will not do so without a written medication order from my prescriber. If I desire to have any such alterations made to my medication or independence, I will discuss the matter with my Riverbend clinical team.
3. Fellowship Housing will maintain a record of my service participation, including any instances of missed services, which will be kept in confidence in conformance with policies regarding Confidentiality and Client Rights and Protection procedures. This record will be reviewed by my Riverbend clinical team as needed.

**I understand these conditions.**

**I accept responsibility for the following:**

1. I am responsible for participating actively in the Medication Support Services program and for asking questions as needed.
2. I am responsible for arranging the payment to my chosen pharmacy of any co-pays I may be responsible for.
3. I am responsible for acquiring and self-administering any medications necessary to treat any medical conditions I may have.
4. I am responsible for notifying Fellowship Housing staff if I am dissatisfied with any part of the Medication Support Services program.
5. I am responsible for advising my Riverbend case manager if I wish to end my participation in the Medication Support Services program.

**I accept these responsibilities.**

**SIGNATURES:**

**Applicant/Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Case Manager:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**FHO Staff Member:** \_\_\_\_\_ **Date:** \_\_\_\_\_

\_\_\_\_\_ **Application Accepted** \_\_\_\_\_ **Application Not Accepted** \_\_\_\_\_ **Application Pended**