

**DEVELOPMENTAL DISABILITIES DIVISION ADMISSION AGREEMENT
AND CONSENT TO TREATMENT
CSH-494**

Completed in full by Developmental Disabilities Division on an annual basis at the time of required yearly assessments.

This admission agreement is applied to Voluntary Mentally Retarded clients under age 18. If further habilitation is deemed necessary, the admission agreement shall be extended for a period not to exceed twelve months, without reassessment.

Distribution: Parent/Legal Guardian
Medical Record

**DEVELOPMENTAL DISABILITIES DIVISION
ADMISSION AGREEMENT
AND CONSENT TO TREATMENT**

_____ is being admitted to _____ Developmental Disabilities Division/Central State Hospital for a period not to exceed _____ without reassessment. Prior to the end of that period of time, he/she shall be reassessed as to his/her need for further habilitation. If further habilitation is deemed necessary, the admission shall be extended for a period not to exceed, without reassessment, twelve (12) months. The decision for continued habilitation will be reviewed at least annually thereafter.

If _____ condition changes to the degree that continued habilitation at Central State Hospital is not deemed in his/her best interest, he/she shall be discharged to a more appropriate setting.

If during his/her admission to Central State Hospital, a more appropriate setting is identified, procedures shall be initiated for placement in such a setting.

While _____ is a client at Central State Hospital, the first representative shall participate in the planning and implement of _____ plan of care. This participation shall include, but not to be limited to, attending team conferences, discharge planning, and not be limited to, attending team conferences, discharge planning, and serving as _____ advocate while he/she is in residence.

While _____ is in residence at Central State Hospital, the first representative shall assist in the exercise of _____ civil and legal rights and the rights of a client.

I understand that while _____ is a client at Central State Hospital, he/she will receive services deemed appropriate by the staff of the hospital. I apply for and consent to such medical treatment as the physicians of the Developmental Disabilities Division and Central State Hospital may prescribe, including diagnostic tests.

I have read the above Admission Agreement and Consent to Treatment, understand and agree to abide by these terms during _____ admission to the Developmental Disabilities Division/Central State Hospital.

SIGNED: _____

DATE: _____

WITNESSED: _____

DATE: _____

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