THE KEARNEY CENTER
Opening Doors to Opportunity, Housing, Independence

ADDRESS: 2650 Municipal Way
Tallahassee, FL 32304
PHONE: (850) 792-9000
FAX: (850) 536-6053
EMAIL: info@kearneycenter.org
WEB: www.KearneyCenter.org

Discharge Agreement

Before discharging individuals to The Kearney Center, discharge personnel should speak directly to a Kearney Center representative concerning that person's plan of care. Discharge personnel also need to submit a completed discharge agreement to The Kearney Center. Along with this document, please attach the patient's current plan of care, current list of medications, and any other supporting medical documents.

The Kearney Center is emergency housing for individuals who have no other place to stay. Staff at The Kearney Center are not equipped to serve patients that need ongoing daily medical assistance and are unable to perform the general activities of daily living including, but not limited to: bathing, grooming, feeding, toilet use, mobility, and bedding transfers. The Kearney Center is unable to meet the needs of everyone; patients must be able to care for themselves. We need to be made aware of any emergency medical concerns and mental health issues, so that we can notify staff to ensure the safety of the patient, as well as others.

We consider every reasonable attempt to coordinate discharge of a patient or client from your facility to The Kearney Center. To facilitate this, we require that discharge planning and coordination begin by contacting the Center during normal business hours (8:00am- 4:30pm), Monday-Friday at (850)-792-9000 x 100. Failure to properly coordinate with Center staff may result in the patient or client being denied access to our facility.

Patient Release of Information
This Release of Information authorizes The Kearney Center access to your discharge instructions, summaries, and medications list. The information collected is used for the purpose of Coordination of Treatment/ Continuity of Care. By signing below, you are agreeing to allow The Kearney Center access to the information collected on you by:

REFERING AGENCY:
Name of Referring Medical/Mental Health Facility: _____
Name of Referring Staff Member: _____
Contact Information for Referring Staff Member: _____

AUTHORIZATION FOR RELEASE OF INFORMATION:
Printed Name:_____
Signature of Patient: _____
DOB: _____
Date: _____
This authorization will expire on _____ If no date is specified, it will expire ninety (90) days after the date signed.

PERSON TO USE (RECEIVE) INFORMATION:
Name (Release): The Kearney Center
Address: 2650 Municipal Way, Tallahassee FL 32304
Phone: (850)-792-9000 x 100
Fax: (850)-536-6053