Please send completed form to:
Admissions - CooperRiis
101 Healing Farm Lane
Mill Spring, NC 28756
828-894-7140 Phone / 828-894-7111 Fax
Call or email admissions@cooperriis.org with any questions.
Additional forms at wwww.CooperRiis.org

Family Form for Application to CooperRiis

Applicant's Name _____

Applicant's Social Security Number _____ Date of Birth _____/_____/_____

CooperRiis' Pledge: We will do our best to provide your family member with a beneficial, comprehensive program of the highest quality, which should assist him or her in recovering from mental illness or emotional distress. Please help us to know of relevant background information:

Your vision: Your family member will, of course, have his/her own vision or dream statement. We are also interested in your current hopes for him/her and for his/her future. Please write a brief statement that captures your desire and hope for your family member's recovery. What is *your* vision? What are some of the key things you hope CooperRiis will help your family member to achieve or accomplish? *(You are welcome to use extra sheets.)*

Disclosure: The CooperRiis environment is open. There are no locked gates and we do not provide one-on-one supervision or staffing. Therefore, risky behavior can be difficult to monitor. Given this, we ask that you answer the following questions carefully, using a separate sheet of paper if necessary.

What is your assessment about whether or not the applicant is currently at risk of suicide or inclined in any way to be destructive or abusive toward himself/herself or others? Be specific as well about the history of such behavior.

_____

_____

What is your assessment of the applicant's ability of the following:

a) to be responsible for his/her own behavior and safety in an open rural or urban environment?

_____

b) to care for his/her personal hygiene?

_____

c) to be able and motivated to participate in the CooperRiis program?

_____

d) to refrain from using alcohol and illegal drugs and to confine cigarette smoking to designated areas?

_____

e) to function relatively independently and safely without close supervision?

_____

By signing below I am indicating that I have provided the most accurate and truthful information regarding these crucial issues related to the safety and welfare of my loved one.

Signature: _____ **Relationship to Applicant:** _____

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We will offer our private, not-for-profit, professionally staffed program for a reasonable fee. CooperRiis has been built entirely from private philanthropy and continues to attract donations so that need-based rate reductions may also be offered after the first two months of residency to families who are unable to pay our standard fee.

We ask that you read, answer and agree to statements a) through e). ***Please initial all items.***

As parent(s), guardian, or spouse, of, _____, I (we)
Applicant's Name

a) _____ Agree to pre- pay CooperRiis' monthly program fee of $18,500 for the first month, plus a refundable security and incidental expense deposit of $1,000, upon admission. I (we) understand that fees are to be pre-paid on a monthly basis, from the day of arrival and that no refund allowances will be made for early discharges. Charges are also not reduced when a resident is away from the campus for trips home, for hospitalization, or vacations. In order to qualify for a rate reduction, the full rate of $18,500 must be paid for the first two months.

Financial Assistance Explanation: After two months of residency, parents, spouse or guardians, who are unable to sustain payments of the standard monthly fee after the first two months of full rate, may seek a rate reduction. We will strive to meet the family's financial circumstances, especially for those residents who are demonstrating a strong commitment to their recovery.

CooperRiis seeks to offer rate reductions based on the financial situation of the resident, of his or her parents (even if divorced), and/or of the resident's spouse or life partner (if there is one). If a reduced rate is set, pre-payments on a monthly basis will still be expected. Rate reductions will be limited to six month increments at each level of the program.

Additional mutual obligations: We are committed to communicating with you, as much as the law allows, about the applicant, during his or her residency. We will encourage the applicant to sign release of information forms that will authorize us to keep you fully informed about his or her condition. We hope that we will only be bringing you positive news. Nonetheless, despite our best efforts, this may not always be so. **We may even approach you at an inopportune time and ask that you pick up the applicant immediately because of medical, psychiatric, legal, or behavioral reasons.**

b) _____ As the individual or individuals willing to take responsibility for the applicant, I (we) agree to come for him or her at once, if the Chief Program Officer or Managing Director asks us to do so.

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Family Form for Application to CooperRiis *(Continued)*

c)_____ I(we) agree to participate in CooperRiis' Family Education programs, which include at least one on-site, three day experience and participation in an online education program. This will be further explained and scheduled through your family member's recovery coordinator.

d)_____ I(we) also understand that the CooperRiis monthly fee does not include external physicians' fees, medication, dental care, personal entertainment or transportation costs, phone calls, etc. Families often ask, "What are the costs for any additional services that are not covered by the standard CooperRiis fee?" The primary extra costs are:

***Psychiatrist**: I (we) understand that fees for Psychiatric treatment will be billed to me (us) in addition to the monthly CooperRiis program fee, and I (we) will agree to pay these fees upon receipt of the billing.*

***Pharmacy:** I (we) understand that it is likely that my (our) family member will receive psychiatric medications and CooperRiis orders these medications on behalf of my (our) family member from a Pharmacy. Also understand that the Pharmacy has the ability to bill the bulk of the costs for the medications to public and private insurance, if my family member has access to this coverage. Understand that I (we) are obligated to pay for any medication costs that are not covered by any existing insurance coverage.*

***Dietary Supplements**: I (we) understand that sometimes residents are advised to take supplements in addition to their regular medications by our Psychiatrists and our nutritionist. If so, I agree to these extra costs.*

***Personal Transportation:** I (we) understand that residents sometime require personalized transportation to airports, doctor's appointments, internships, etc. and that I will be obliged to pay for these extra services*

***Drug Screens:** I (we) understand that residents with drug use/abuse histories are required to submit to regular random drug screens as deemed appropriate by their CooperRiis Treatment team. If my family member is required, I(we) agree to these extra costs.*

*e)_____ I(we) also understand that CooperRiis is NOT an in-network provider with any insurance carrier and therefore does not accept insurance. We do however work with a third party billing and utilization management company, **SJ Health Insurance Advocates**, that will work with our residents and their families directly to help secure insurance reimbursement using the resident's out of network insurance benefits when applicable. We encourage all residents and families to review their insurance benefits with SJ Health Insurance Advocates to see if reimbursement is possible.*

*f)_____ I(we) understand that CooperRiis is **not a Medicare/Medicaid provider** and do not bill Medicare or Medicaid. If your family member is on Medicare or Medicaid, they will be asked to sign a 'private contract' that waives our (and their) right to bill Medicare or Medicaid for the services of any of our mental health professionals. This 'private contract' will allow us to bill you directly for the services that are described on this Family Form.*

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Family Form for Application to CooperRiis *(Continued)*

I (we) pledge to comply with the requirements listed in a) – f):

First Signature: _____ Date: _____

Printed name: _____ Relationship: _____

Address: _____

Home Phone: ( ) _____ - _____ Work Phone: ( ) _____ - _____

Cell Phone: ( ) _____ - _____ Email: _____

Additional Signature: _____ Date: _____

Printed name: _____ Relationship: _____

Address: _____

Home Phone: ( ) _____ - _____ Work Phone: ( ) _____ - _____

Cell Phone: ( ) _____ - _____ Email: _____

Please give us a contact to reach in an emergency, if you can not be reached:

Name: _____ Relationship: _____

Address: _____

Home Phone: ( ) _____ - _____ Work Phone: ( ) _____ - _____

Cell Phone: ( ) _____ - _____ Email: _____

Medical Insurance Information: <u>(Please attach copies of all insurance cards for Pharmacy.)</u>

**Note: CooperRiis does not file with Medicare/Medicaid or private insurance*.