Department of Homeless Services
Department of Social Services

NEW YORK CITY DEPARTMENT OF HOMELESS SERVICES
REFERRAL FROM HEALTHCARE FACILITIES POLICY

Procedure number: DHS-PB-2018-009

SUBJECT:	**APPLICABLE TO:**	**ISSUED:**
Referral from Healthcare Facilities to DHS Single Adult Facilities	All Single Adult Shelters/Safe Havens and DHS Single Adult Intake Sites	June 28, 2018

ADMINISTERED BY:	**APPROVED BY:**
Office of the Medical Director	Joslyn Carter, Administrator Department of Social Services/ Department of Homeless Services

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PURPOSE

The purpose of this document is to describe the process for referral and acceptance into the Department of Homeless Services (DHS) shelter and streets solution system of single adult clients from inpatient departments of healthcare facilities (HCF) including acute and long-term care facilities (LTCF), and to describe criteria for medical appropriateness for shelter and other DHS facilities. Emergency departments (ED) are not required to follow this procedure.

As per New York State regulations 18 NYCRR Part 491.4: "The operator shall not accept, except on an emergency basis, not retain any person who:

(1) Causes danger to himself or other or interferes with the care and comfort of other residents;
(2) Is in need of a social, religious, cultural or dietary regimen that cannot or will not[1] be met by the facility;
(3) Is in need of a level of medical, mental health, or nursing care that cannot be rendered safely and effectively by approved community resources;
(4) Is incapable of ambulation on stairs without personal assistance unless such a person can be assigned a room on a floor with ground level egress; or
(5) Is under 18 years of age."

OVERVIEW OF DISCHARGE GUIDELINES

DHS provides shelter as a last resort and as a temporary emergency residence while shelter clients are seeking permanent housing. Only medically appropriate, meaning physically and mentally independent, individuals can be admitted into the Single Adult Shelter System. DHS also provides services to street homeless individuals. The following is an overview of this guidance:

- No individual should be referred to the DHS shelter system from an HCF without a complete HCF-DHS Referral Form submitted to DHS and receipt of approval of the referral. The Referral Form can be found at: https://www1.nyc.gov/site/dhs/shelter/singleadults/single-adults-hospital.page and in Appendix 1 (**DHS-14**).
- The review of the Referral Form prior to discharge from an HCF ensures that the client, upon discharge, does not require a level of care and monitoring that exceeds both DHS's ability and legal obligations. DHS reserves the right to request documents necessary for the determination of medical appropriateness for shelter, including psychiatry notes, Patient Review Instrument (PRI) and SCREEN as needed for selected cases.

[1] For patients with a dietary regimen, disabling condition due to a medical condition or disability, please attach a completed DHS Reasonable Accommodation Request Form (https://www1.nyc.gov/assets/dhs/downloads/pdf/client-accom-request-form.pdf) with the completed Referral Form (Appendix 5 [**DHS-13**]).

- The HCF is responsible for documenting in writing in their records a client's consent to share medical information with DHS and affiliated providers. Before being referred to DHS, the client's verbal consent to referral to DHS is required, and should be documented on the Referral Form. A client's consent to enter the DHS system is not required prior to sharing clinical information with DHS for the referral.
- In general, clients residing in skilled nursing facilities or receiving long-term care have a high likelihood of being medically inappropriate for shelter. DHS will consider such clients after review of the Referral Form and discussion with the HCF, as needed.
- For homeless clients new to shelter, the HCF is expected to assist the client in identifying housing resources and alternative safe discharge plans, and include the results of these attempts on the Referral Form.
- Clients coming from shelters/Safe Havens may be discharged back to the same shelter/Safe Haven only if it is a safe discharge.
- The HCF should include any medical or behavioral health follow-up information in their safe discharge plans and communicate them in writing to the relevant DHS facility.
- For clients requiring a medically-restricted dietary regimen or with a disabling condition, the HCF should include supporting documentation for a reasonable accommodation request. The Reasonable Accommodation Request Form can be found here: https://www1.nyc.gov/assets/dhs/downloads/pdf/client-accom-request-form.pdf and in Appendix 5 (**DHS-13**). The supporting documentation consists of a clinician letter, signed by the treating clinician that describes the condition related to the accommodation request and the accommodation needed.
- DHS and the HCF will cooperate with HIPAA requirements in the exchange of information for shelter referral.
- The HCF will receive a response from DHS within **1 business day of receipt of the Referral Form for length of stay of less than 30 days and 2 business days of receipt of the Referral Form for length of stays greater than 30 days**. The DHS response will be either (a) approval; (b) request for more information; or, (c) denial of the referral. Business days and hours are Monday-Friday from 9:00am-5:00pm. If the HCF doesn't hear back from DHS within the stated timeframe, the client can be discharged.
- Any instance of an HCF knowingly referring a client to a DHS facility without a DHS-approved Referral Form may be reported to the New York State Department of Health and to the HCF Chief Executive Officer and/or Chief Medical Officer.
- All discharges of a client from an HCF (inpatient departments) to DHS should occur Monday-Friday 9:00am and 3:00pm and, for medically fragile clients, be coordinated with the relevant DHS site. Necessary services should start on the day of discharge.

OVERVIEW OF THE DHS SHELTER SYSTEM

For the purpose of this procedure, the "DHS shelter system"[2] is any homeless shelter facility directly-operated or contracted by DHS. The DHS shelter system includes but is not limited to, intake sites, assessment shelters, and program shelters. DHS oversees all social service programs provided by DHS or its vendors to homeless persons seeking shelter, receiving shelter, or departing from such shelters, including outreach to street homeless, drop-in centers, and Safe Havens.

There are no shelters, Safe Havens, or Drop in Centers (DIC) that have medical services appropriate for clients with medical or disabling conditions that fall within the absolute exclusion criteria detailed on pages 6-7.

There are no medical or respite shelters in the DHS shelter system.

Single Adult Shelters

The Single Adult Shelter System consists of facilities which provide beds in congregate spaces with congregate or shared bathrooms. There are three intake sites (two for women, one for men) where entry into the system is processed if diversion from shelter is unsuccessful, and six assessment shelters where clients are assessed to determine which type of shelter will best meet their needs. DHS operates specific program shelters which include general/employment shelters, mental health shelters, substance use shelters, and a small number of semi-specialized shelters (for veterans, young adult, young adult identifying as LGBTQI, and older adults). Mental Health and Substance Use shelters are served by mental health and substance use providers and provide ambulatory clinical care (on-site or by referral), behavioral health services (on-site or via referral), crisis prevention and de-escalation, and social services. Clients who require a Mental Health Shelter placement must be linked to community mental health treatment prior to referral to DHS. Mental Health Shelters **do not** provide skilled nursing services, assistance with activities of daily living, or supervised medication administration.

Due to the congregate nature of the single adult shelters, home care is not possible outside of limited services from nurse visits, such as wound care on a case-by-case basis.

DHS Street Solutions

Outreach Teams

Outreach programs operate 24 hours a day/7 days a week/365 days a year, deploying teams to streets and subway system to engage street homeless individuals and encourage them to move into shelter or housing. The programs operate under a Housing First approach where access to housing is offered as quickly as possible with supportive services on-site and through community providers. Outreach providers have direct or subcontracted medical and psychiatric services and connect people to partner medical and psychiatric providers.

[2] DHS also manages shelters for families with children under 21 and adult families. These shelters are unique in their needs and services, and fall outside the scope of this protocol.

Safe Havens

DHS oversees a system of facilities called Safe Havens, which were created as a resource for chronically street homeless clients who are not willing to enter the traditional shelter system. Referrals to Safe Havens can only be made by DHS-contracted street Outreach Teams after they have established a client's street homeless chronicity. The Safe Haven model is a low-threshold temporary residential setting offering a safe place to sleep and stabilize while alternative housing options are explored. Safe Havens have flexible requirements, such as no curfew and a flexible approach to working with the variety of behaviors and situations a chronically street homeless client may present. All Safe Havens provide meals and snacks onsite. Most have on-site medical care for episodic needs, but are insufficient for people who meet the absolute exclusion criteria.

Drop-In Centers

Drop-in Centers operate 24 hours/7 days a week/365 days a year, providing hot meals, showers, laundry facilities, clothing, medical care, on-site mental health services, and case management. Medical services vary by program and all have linkages to mental health providers and inpatient/outpatient substance use programs. Drop-in centers do not have beds and do not provide medical or nursing services sufficient for persons who meet the criteria for medical inappropriateness for shelter, and are not an appropriate discharge plan.

CRITERIA FOR MEDICAL APPROPRIATENESS, RELATIVE EXCLUSION, AND ABSOLUTE EXCLUSION

All individuals referred to DHS facilities must be able to independently care for themselves. DHS does not operate medical or respite shelters, and its facilities do not provide on-site home care.

Medical Appropriateness Criteria

Individuals with medical or disabling conditions who are appropriate for shelter can be referred to DHS. They can receive a reasonable accommodation(s) for their needs. Examples include but are not limited to:

- Assistance with wound care up to twice a day by a visiting nurse, if the wound is not weeping and draining;
- Access to a temporary bed for rest/convalescence with day-bed pass;
- Accessible bathroom and/or accessible site, including placement on first floor and/or in a building with an elevator, and a bed with adjustable height;
- Access to a refrigerator for medication storage;
- Monthly assistance with medication arrangement in pill boxes by visiting nurses;
- Post-discharge nurse visit for daily medication assistance up to 2 weeks;
- Medically necessary diet, for example, renal and diabetic meals; and
- Oxygen concentrator (not tank or canister/cylinder).[3]

Relative Exclusion Criteria[4]

The following clinical conditions require a discussion with the DHS Office of the Medical Director (OMD) prior to referral approval. The HCF will include on the Referral Form a description of the client's medical condition(s) and functional needs that fall into the relative exclusion criteria listed below. If necessary, DHS will contact the HCF to discuss the case. The client must be independent in managing all activities of daily living (ADLs) and the conditions listed below:

- Gastrostomy tube (client must have their own access to the nutrients for the gastrostomy tube);
- Intra-muscular or intra-venous medication administration for acute condition only (up to twice per day, for no more than 2 weeks by a visiting nurse, and prearranged by the HCF);
- Tracheostomy (client must be able to care for the tracheostomy and live in a congregate setting);
- Infusion pumps or PICC line;
- Colostomy (client must be able to care for the colostomy and bag).[5]

[3] Provide clinical support documentation for Reasonable Accommodation request (Appendix 5 [**DHS-13**]).

[4] For a homeless individual in need of life-saving surgery or treatment such as organ transplant, email the DHS Office of the Medical Director at HCF-DHSreferral@dhs.nyc.gov to discuss the case and if the client will be medically appropriate to return to shelter.

[5] Disposable bags are preferred as there are no private bathrooms available;

Absolute Exclusion Criteria[6]

The following absolute exclusion criteria render a single adult client de facto medically inappropriate for DHS facilities:

- Inability to care for self and independently manage activities of daily living; use the ADL Assessment Form included on the Referral Form. An ADL score <12 indicates medical inappropriateness for shelter. The DHS ADL Assessment For Institutional Referrals form must be completed by a clinician on the client's team (Appendix 2 [**DHS-14a**]);
- Lack of decisional capacity;
- Need for home care or nurse visits beyond wound care or IM/IV medication administration and beyond 2 weeks;
- Severe immunosuppression (chemotherapy, end-stage AIDS, post-transplant, with an Absolute Neutrophil Count (ANC) <500mL);
- Major dementia with cognitive deficits (MMSE <25);
- Inability to understand spoken, signed, visual, or tactile language with or without an interpreter;
- Inability to make needs known or follow commands;
- Poses imminent risk of physical harm to themselves or others;
- Inability to independently manage chronic illnesses or medication administration, schedule, and reminders, including inability to self-administer insulin;
- Inability to independently manage urinary catheters;
- Peritoneal dialysis;
- Inability to manage urinary or bowel incontinence or explosive diarrhea;
- Oxygen-dependence requiring an oxygen tank/cylinder of any size, containing liquid or compressed oxygen;
- Unresolved delirium;
- Cranial Halo Devices or stabilizing protective gear worn continuously; or
- On a ventilator.

Note: HCF should advise DHS if a client has a history of arson- recent fire setting.

A client should never be discharged to the streets under any circumstances.

[6] Single adult women who are pregnant and in need of shelter should be referred for shelter placement to PATH.

COORDINATION OF CARE

Coordination of care consists of discharge coordination, follow-up care planning, and guidance on special cases. It is the responsibility of the DHS facility and of the HCF to coordinate the safe discharge of clients. This coordination is essential for medically fragile clients and recommended for others who need follow-up care to remain stable. It is the responsibility of HCFs to organize follow-up care prior to discharge. While in shelter, it is the responsibility of the DHS facility to assist clients in keeping follow-up medical appointments.

Once an HCF determines that a client is or may become homeless, the HCF should call the **DHS Referral Line at 212-361-5590** to determine if the client is a current DHS client or has been in a DHS facility within the last 12 months or is known to Outreach. Regardless of whether the client is new to the DHS system or a returnee, all aspects of this procedure should be followed, including determination of medical appropriateness prior to discharge and coordination of care. If the client is a current DHS client, or has stayed in a DHS facility in the past year, the HCF will be informed of the client's facility of record, and of the phone number and address where the completed Referral Form should be sent. The HCF will also be informed if the client is known by a street homeless Outreach Team. If the client leaves the HCF against medical advice, the HCF should immediately inform the appropriate DHS facility and email them the Referral Form (if completed) and as much information about the client's medical condition as possible.

Discharge Coordination

If it is medically necessary for the client to receive a bed immediately at time of discharge and upon arrival at the Intake Site, shelter or other DHS facility, and cannot wait for a bed at nighttime, or the client is in need of immediate follow-up care and/or intensive care coordination, the HCF must communicate this need to the receiving Intake Site or shelter directly as described below. This does not apply to clients who are not medically fragile.

New clients:

- For clients who are medically appropriate but still have complex medical needs, the HCF will:
  - Indicate the client's functional needs on the Referral Form;
  - If needed, include a complete Reasonable Accommodation Form and clinical supporting documentation; and
  - Inform the Intake Site of the client's impending arrival and needs.

New male clients

OMD will:

- Upload the Referral Form in the DHS Data System (CARES or StreetSmart)
- Add a managerial flag to the applicable DHS Data System regarding the client's medical needs including duration and Reasonable Accommodation(s)

30th St. Intake will:

- Coordinate with the HCF to manage the discharge
- Ensure the client is assigned a bed as soon as needed

New female clients

Franklin/Help Women Center will:

- Upload the Referral Form into the DHS Data System
- Add a managerial flag to the applicable DHS Data System regarding the client's medical needs including duration and Reasonable Accommodation(s)
- Coordinate with the HCF to manage the discharge.

Returning clients:

- For medically appropriate clients who have complex medical needs, the HCF will indicate the needs on the Referral Form.
- The HCF will contact the DHS facility of record during the day to verify if the client will have a bed there at time of discharge. If no bed is available at the facility of record, the facility director will work with vacancy control to find an alternate bed and inform the HCF of where to send the client.
- It is the responsibility of both the DHS facility and the HCF to coordinate the discharge of the client.
- The DHS facility of record will:
  - Add a managerial flag to the DHS Data System regarding the client's medical needs
  - Coordinate with the relevant HCF to manage the discharge
  - Ensure there is a bed for the client before discharge
- HCF will:
  - DHS recommends that for medically fragile clients who need a bed immediately upon arrival, the client is kept at the HCF until a shelter bed is assigned. This is on a case by case basis and based on conversation with the shelter, and only for few hours or a day. The time of discharge will then be negotiated with the shelter.

Follow-up Care Planning

For clients with persistent medical conditions:

HCF will:

- Arrange discharge follow-up care including transportation and nurse visits.
- For clients with renal insufficiency on dialysis, arrange for dialysis, provide all relevant information to the client, and establish that the client can travel independently to the dialysis center. If the client cannot travel independently, the HCF should arrange for transportation to the center prior to discharge.
- Provide, at minimum, a two week medication supply to the client upon discharge, unless otherwise directed by the client's primary care provider.
- Oxygen tanks and cylinders are not allowed in NYC DHS shelters. If the client is in need of oxygen, the HCF should assist the client in obtaining an oxygen concentrator prior to discharge.
- Note that referrals to walk-in clinics do not constitute adequate follow-up care arrangements.

- Communicate the follow-up care plan and dates, times, and locations of all appointments in writing to the client, and to OMD and the relevant DHS facility, Intake Site or outreach team (Appendix 7 [**DHS-14e**]).

The DHS facility staff will:

- Assist clients in keeping follow-up appointments
- Assist clients with prescription pick-up
- Update this information in the respective DHS Data System.

Special Cases
Ambulatory surgery is not recommended for clients residing in a DHS facility. Lack of medically-trained staff support for the client immediately after ambulatory surgery, lack of monitoring of the client post-op, and the possibility that the DHS facility will not be able to accommodate the new medical needs of the client make this a last resort for all single adult DHS clients. It is recommended that the client be allowed at least one overnight stay in the hospital to monitor complications of surgery and ensure a safe and appropriate discharge plan. If ambulatory surgery cannot be avoided, prior to the scheduling of a surgery:

- The client's doctor will
  - Speak directly with the Director of Social Services (or on-site medical provider if one exists for the shelter) to ensure continuity of care once the client is discharged.
  - Communicate and coordinate with staff at the DHS facility.
- DHS facility staff will
  - Transfer the client via a reasonable accommodation if the current shelter is no longer appropriate for the client.

REFERRAL PROCEDURE

Referrals of clients who are new to the Single Adult Shelter System or have not been in shelter in the last 12 months[7]

Responsibilities of the HCF upon client admission and during inpatient stay:

- The HCF will perform a housing screening to determine if a client is unstably housed, newly homeless, or at risk of losing their housing during their inpatient stay. See example of a housing screening tool in Appendix 3 (**DHS-14b**). Once a client has been determined to be unstably housed or at risk of homelessness, the HCF is expected to perform a housing assessment and assist the client in accessing homelessness prevention services through HRA (access to, and information about HRA services are available at http://www1.nyc.gov/site/hra/help/homelessness-prevention.page). For further information with assisting clients in obtaining housing, see Appendix 4 (**DHS-14c**).
- HCF staff are encouraged to start discharge planning early in the HCF inpatient stay to ensure time for housing consultation and application.
- HCF are expected to **make every effort to prevent a client from entering the homeless shelter system and assist the client in returning to his or her pre-admission housing setting or another form of non-shelter housing.** The HCF should document all efforts, as applicable to each client situation, to secure non-shelter housing on the Referral Form.
- If it is discovered that the client is homeless, the HCF should complete the HRA 2010e supportive housing application for all potentially eligible clients. Supportive housing information can be found here: https://shnny.org/learn-more/looking-for-housing/supportive-housing-in-new-york-city, and eligibility criteria here: http://www.coalitionforthehomeless.org/get-help/im-in-need-of-housing/supportive-housing/eligibility-for-supportive-housing/. This application can be completed by a Licensed Clinical Social Worker, Licensed Psychiatric Nurse Practitioner, Licensed Psychologist, and Psychiatrist (as of March 2017).
- The Office for People with Developmental Disabilities (OPWDD) is responsible for Residential Support for individuals when there is an emergency need that includes homelessness, risk of homelessness, and discharge from a hospital or emergency department. See https://opwdd.ny.gov/opwdd_services_supports/residential_opportunities/Residential_Support_Categories
  - If the client has diagnosis of or if there is reason to believe that they have a diagnosis of (or shows signs of) a developmental disability including: an intellectual disability; autism spectrum disorder; cerebral palsy; neurological impairment; seizure disorder; or any diagnosis that manifests similarly to intellectual disability.
    - Check for eMedNY/ePACES codes:
      - 95: indicates that the client has established OPWDD eligibility.
      - 44, 45, 46: indicates that the client has an established living situation and that they are enrolled in the OPWDD Home and Community-Based Services (HCBS) waiver and receives community based services.

[7] This section does not apply to existing shelter residents who are admitted to a HCF. For existing or recent shelter residents, Referral of Patients who are Returning to DHS, Section B.

- 48, 49: indicates what type of OPWDD residential setting the client resides in.

- If these codes do not appear, the client may not yet be known to OPWDD or the client may not be Medicaid eligible. Contact OPWDD, request support from them and take note of the client's status with OPWDD and who was spoken to and their contact information.
- If any of these codes do appear, contact OPWDD and confirm the client's status with OPWDD, take note of which codes appear and who was spoken to and their contact information.

To find out if an applicant is already connected to OPWDD, contact the **Developmental Disabilities Regional Offices (DDROs)**
https://opwdd.ny.gov/opwdd_contacts/ddro

Queens: 718-217-5890
Brooklyn: 718-642-6000
Manhattan: 646-766-3222
Bronx: 718-430-0885
Staten Island: 718-983-5233

- If the client appears to be eligible, the HCF should inform clients with Medicaid about Health Homes, encourage participation and, and assist them with Health Home enrollment, if they agree to enroll, and in identifying a primary care provider or clinic, if not previously available. The HCF should include the name of the care management agency and primary care on the Referral Form.
- Client must be medically and psychiatrically stable, and able to manage independently in a shelter setting to be considered appropriate for shelter. Only **medically and psychiatrically appropriate** clients may be referred to the DHS shelter system. The HCF will complete the DHS ADL Assessment Form to assess the client's level of independence in activities of daily living. **If the client's score is under 12, the client is inappropriate for shelter and the Referral Form should not be submitted.**
- Prior to submitting the Referral Form, the HCF must obtain client consent to share medical information with DHS on a HIPAA-compliant consent form.
- In the event the HCF is unsuccessful in assisting the client in securing non-shelter housing AND the client is deemed medically appropriate for DHS shelter based on above criteria, and as certified by the treating physician, the HCF will call the **DHS Referral Line at 212-361-5590** to determine if the client has a currently assigned shelter. If the client is new to DHS, or has not been in a shelter in the previous 12 months, the HCF will ask the client their preferred shelter placement by gender, and will email the completed Referral Form in the timeframe stated on page 3**,** to either:
  - For women: HCFReferral@helpusa.org; or
  - For men: HCF-DHSreferral@dhs.nyc.gov.
  - If the HCF has questions regarding this process, they should email HCF-DHSreferral@dhs.nyc.gov.

New DHS Clients, DHS's Review of completed Referral Form:

- DHS will review the completed Referral Form and request additional information if needed.
- If housing searches and other non-shelter placement efforts and their results are not documented, a request for additional information will be made. Please note that the timeframe for determining the medical appropriateness of a client pauses during the period that the HCF is gathering additional materials and documentation.
- If DHS determines that the client is medically appropriate for shelter, the HCF will be emailed within the timeframe stated on page 3 to confirm appropriateness for discharge, unless the time has been extended due to additional requests for missing or incomplete information. It is the responsibility of the HCF staff to check their email for messages from DHS.
- If, after the stated timeframe of 1-2 business day (based on LOS), the HCF facility has not received a response from DHS, the client can be discharged.
- If DHS determines that the client is medically inappropriate for shelter, DHS will email notification to the HCF as soon as the determination is made, and no later than the stated timeframe after the referral was received, unless the time has been extended due to additional requests for incomplete information. While waiting for further documentation from the HCF, the client cannot be discharged to a shelter.
- If the HCF disagrees with the determination of DHS, the HCF will contact the shelter director to discuss. If no agreement can be obtained, the HCF can contact the DHS medical office at DHS-MedicalOffice@dhs.nyc.gov to discuss and request a review of the determination.
- An HCF discharging clients to a DHS shelter should do so only during the hours between 9:00am and 3:00pm, Monday to Friday. As mentioned above, it is highly recommended that for clients who are medically appropriate and have medical needs that can be met in shelter that the HCF social worker contacts the DHS Intake site to coordinate the discharge, for the benefit of the client.
- On the day of discharge, if new information is available, the HCF will email an updated Referral Form to the Intake Site and will send a copy with the client. The updated Form will include the client's:
  - Current discharge diagnoses;
  - Current medication list;
  - Follow-up appointment(s) date and time;
  - Name and contact information of their Health Home care management agency;
  - Primary care clinic or physician name; and
  - HCF staff contact numbers.
- DHS OMD (for men) or the applicable Women's Intake will upload the Referral Form into the DHS Data System Document Repository and enter requisite information on the Institutional Referral screen.
- If the medically appropriate client requires uncommon reasonable accommodation(s), the HCF needs to communicate with the Intake Site via email. If a bed at an appropriate facility is not immediately available, the Intake Site will ask the HCF via email to hold the client until a bed is available in an appropriate shelter for the well-being of the client. DHS will make all efforts to find a bed as soon as possible.

- For clients with behavioral health conditions admitted to inpatient psychiatry, the HCF is expected to:
  - Arrange follow-up with an outpatient mental health provider, ensure that the provider is identified on the Referral Form and communicate this information to the Intake Site. If the HCF sends the Referral Form early and does not yet have follow-up appointments information, the HCF will send that information any time **prior to discharge**;
  - If indicated, submit a Single Point of Access Application (SPOA) form to the New York City Department of Health and Mental Hygiene (DOHMH) for a mental health services evaluation;
  - If needed by the client, Assertive Community Treatment (ACT), Intensive Mobile Treatment (IMT), and other forms of mental health treatment and support should be arranged prior to discharge;
  - For clients who meet the criteria for Assisted Outpatient Treatment (AOT), a completed application should be submitted prior to discharge and a copy of the AOT order, treatment plan, and assigned provider attached to the Referral Form; and
  - The HCF should work with the ACT team or care coordinator to have the client escorted to the DHS Intake site if needed.
- For clients with chronic medical conditions, the HCF will arrange for follow-up care including nurse visits or dialysis, as needed.

Post-Discharge Process for New Clients

1. **If the discharged client arrives at the intake site in a worse state than stated on the Referral Form:**
   - If the client arrives at the Intake Site and is in need of emergency medical/psychiatric care, or is medically inappropriate, intake staff will call EMS to transport the client, preferably back to the referring HCF, or if not possible, to the nearest hospital after speaking with the HCF social worker for a warm handoff of the client. Staff must inform the DHS Program Administrator immediately.
   - If the client appears medically or psychiatrically inappropriate for shelter, but does not meet the emergency threshold for an EMS call; and
     - The intake site **has a medical provider:**
       - Intake site staff will contact their medical provider to have the client evaluated and will notify their Program Administrator.
       - If the intake site medical provider deems the client is medically inappropriate, they will contact the HCF to discuss the case, and engage in a warm handoff back to the HCF.
       - The Program Administrator will notify the DHS OMD.
       - DHS OMD will contact the HCF to report the inappropriate discharge.
     - The intake site **does not have a medical provider:**
       - The intake site will contact their Program Administrator who will consult with DHS OMD.
       - If DHS OMD agrees that the client seems medially inappropriate, OMD will contact the HCF social worker to discuss the case by telephone, or send an email requesting more information regarding the client.

  - If the client is confirmed to be medically inappropriate for shelter, the client will be transported to the HCF of origin after intake staff communicate with the HCF social worker and via warm handoff. If the HCF refuses to accept the client after discussion with DHS, the Intake Site will accept the client while further discussions occur.
- The DHS facility medical provider or DHS OMD, as appropriate, will contact the HCF to report and discuss the occurrence. If, after discussion with the HCF, it is discovered that the HCF discharged a client knowing that they are inappropriate for shelter, OMD will send a complaint to:
  - The New York State (NYS) Department of Health or the NYS Office of Mental Health;
  - Greater New York Hospital Association (GNYHA); or the appropriate Nursing Home Association; and
  - HCF leadership.

2. **If the discharged client arrives at intake as stated on the Referral Form:**
   - Once the client is placed, shelter staff will work with client to assist them in making all possible follow-up appointments and engage in care coordination with the HCF.
   - Shelter staff will upload the Referral Form and discharge documents.

3. **If the Discharged client arrives at intake without a Referral Form:**
   - If the client appears medically appropriate for shelter, they will be accepted to the facility.
   - If the client appears medically inappropriate for shelter, the Program Administrator should be informed, and they will consult with DHS OMD as needed.
   - If the client is confirmed to be medically inappropriate for shelter, the client will be transported to the HCF of origin after intake staff communicate with the HCF social worker and via warm handoff. If the HCF refuses to accept the client after discussion with DHS, the Intake Site will accept the client while further discussions occur.
   - The DHS facility medical provider or DHS OMD, as appropriate, will contact the HCF to report and discuss the occurrence.
   - If, after discussion with the HCF, it is discovered that the HCF discharged a client knowing that they are inappropriate for shelter, OMD will send a complaint to:
     - The New York State (NYS) Department of Health or the NYS Office of Mental Health;
     - Greater New York Hospital Association (GNYHA); or the appropriate Nursing Home Association; and
     - HCF leadership.

Referrals of Clients who are Returning to a DHS Shelter

The procedure for referral of clients who are returning to the Single Adult DHS Shelter system, or who have resided in the DHS system anytime in the 12 months or less, is below.

If a DHS shelter sends a client to the hospital or is otherwise aware of the client's hospitalization, the shelter staff must communicate with the hospital throughout the admission regarding the client's clinical status, needs, and discharge planning. This is especially important for clients with severe chronic illnesses and those with mental illness sent to the hospital because of an emergency event or crisis.

Role of the HCF upon admission and during inpatient stay of a current shelter client:

- For clients returning to shelter within a year from their exit ("Returnees"), and who were admitted to the HCF while residing in a shelter, the HCF should communicate directly with the shelter of record regarding appropriate discharge of their shared clients/clients.
- The HCF will call the **DHS Referral Line at 212-361-5590** to determine the location and contact information of the Shelter.
- **Note:** If a client has been in shelter in the last year but is coming to the HCF *from non-shelter housing,* all efforts should be made to avoid a shelter referral via similar actions taken for new clients. **Only once all options have been exhausted should the referring HCF contact the previously shelter of record.**
- HCF should begin discharge planning early in the admission, as return to shelter can become inappropriate if the client's functional status has deteriorated since initial placement. Discharge planning should start as soon as the HCF determines a client is homeless, and no later than the timeframe stated at the beginning of this policy.
- The HCF will send the Referral Form to the Returnee's shelter of record for review and clearance by shelter staff.

DHS's Review of completed Referral Form:

- Shelter staff will review the Referral Form within the stated timeframe.
- If the shelter deems that the Returnee is medically inappropriate for shelter, the shelter staff will inform the HCF and the shelter site's Program Administrator, who will notify DHS OMD.
- After reviewing the Returnee's Referral Form, OMD will make a determination and inform the Program Administrator and shelter. The shelter will then notify the HCF of the final determination.
- If the shelter deems the Returnee appropriate for shelter, they will contact the HCF and inform them of the determination.
- HCF should discharge clients only between the hours of 9:00am and 3:00pm Monday through Friday.

- If the HCF discharges the Returnee to a DHS shelter following DHS's determination that the Returnee is medically inappropriate for shelter, DHS will transport the Returnee back to the HCF. **The HCF should not send shelter clients who are medically inappropriate for shelter; it is very disruptive for the client.** If the HCF refuses to accept the client after discussion with DHS, the shelter will accept the client while further discussions occur.
- The shelter will upload the Referral Form into the DHS Data System Document Repository for continuity of care and enter the requisite information in the client record.

Post-Discharge Process:

1. **If the discharged client arrives at the shelter in a worse state than stated on the Referral Form:**
   - If the client arrives at the Intake Site and is in need of emergency medical/psychiatric care, or is medically inappropriate at discharge, intake staff will call EMS to transport the client, preferably back to the referring HCF, or if not possible, to the nearest hospital after speaking with the HCF social worker for a warm handoff of the client. Staff must inform the DHS Program Administrator immediately.
   - If the shelter staff observes that the client is medically or psychiatrically inappropriate for shelter, but does not meet the emergency threshold for an EMS call, one of the following scenarios will be followed:
     - The shelter **has** a medical provider
       - Shelter staff will contact their medical provider to have the client evaluated and will notify their Program Administrator.
       - If the shelter medical provider agrees that the client is medically inappropriate, they will contact the HCF social worker to discuss the case, and arrange for transportation back to the HCF, with a warm handoff.
       - The Program Administrator will notify OMD.
       - OMD will contact the HCF to inquire about the reasons for the inappropriate discharge and remind the HCF of the policy.
     - The shelter **does not** have a medical provider
       - The shelter will contact their Program Administrator who will consult with the DHS OMD.
       - After consultation with the shelter staff/Program Administrator, if OMD agrees with the shelter's concerns, the Office will contact the HCF social worker to discuss the case by telephone or email.
     - If the client is confirmed to be medically inappropriate for shelter, they will be transported back to the HCF with a warm handoff. If the HCF refuses to accept the client, a bed will be given temporarily until the situation can be sorted out with the HCF.
   - If, after discussion with the HCF, it is discovered that the HCF discharged a client knowing that they are inappropriate for shelter, OMD will send a complaint to:
     - The New York State (NYS) Department of Health or the NYS Office of Mental Health;
     - Greater New York Hospital Association (GNYHA); or the appropriate Nursing Home Association; and
     - HCF leadership.

2. **If the discharged client arrives at shelter as stated on the Referral Form:**
   - Shelter staff will assist clients in keeping follow-up appointments and engage in care coordination with the HCF.
   - The shelter will upload the Referral Form into the DHS Data System Document Repository and enter the requisite information in the client record.

3. **If the Discharged client arrives at a shelter without a Referral Form:**
   - If an HCF discharges a client to a DHS shelter without having first sent the Referral Form, upon arrival at a shelter, the client will be assessed by the on-site medical provider or Intake staff, and the DHS OMD will be consulted as needed.
   - If the client is found medically appropriate for shelter, the shelter will accept and provide a bed to the client.
   - If the client is confirmed to be medically inappropriate for shelter, the client will be transported to the HCF of origin after shelter staff communicate with the HCF social worker and with a warm handoff. If the HCF refuses to accept the client after discussion with DHS, the shelter will accept the client while further discussions occur.
   - The DHS facility medical provider or DHS OMD, as appropriate, will contact the HCF to report and discuss the occurrence. If, after discussion with the HCF, it is discovered that the HCF discharged a client knowing that they are inappropriate for shelter, OMD will send a complaint to:
     - The New York State (NYS) Department of Health or the NYS Office of Mental Health;
     - Greater New York Hospital Association (GNYHA); or the appropriate Nursing Home Association; and
     - HCF leadership.

Referrals of Clients who are Street Homeless

Responsibility of the HCF upon admission and during inpatient stay of a street homeless client:

- If the client is known to an Outreach Team and the Team was aware that the client was going to a HCF, the Team's Medical Provider will communicate with the HCF concerning the reasons for admission and throughout the client's stay.
- For all street homeless persons, the HCF will contact the Street Homeless Teams (see Outreach Team contacts Appendix 6 [**DHS-14d**]) and verify that:
  - No viable alternatives to shelter have been identified by the HCF, including but not limited to nursing homes, supportive housing, and family reunification;
  - The client is not amenable to entering the shelter system; and
  - The client is medically and mentally stable and can perform their ADLs as documented in the DHS ADL Assessment For Institutional Referrals Form, Appendix 2 (**DHS-14a**) with or without durable medical equipment, such as a wheelchair.
- If the client meets the criteria above, the HCF will ask the client if they receive services from an Outreach Team and in which borough they receive these services. The HCF will then contact the respective borough Outreach Team, to determine if the client is known to them.

Review by Street Outreach Teams:

- If the client is known to the Outreach Teams, they will evaluate existing placement options, and make best efforts to visit the client at the HCF for assessment. Regardless of whether they know the client or not, the Outreach Teams will work with the HCF to assist with a street homeless client placement and/or transportation if at all possible.
- If a street homeless client is not known to DHS and is willing to enter shelter, the HCF will follow the process detailed in Referrals of New DHS Clients, Section I. If the client will not accept shelter, the HCF will complete the Referral Form and send it to the Outreach Team within the timeframe stated on page 3.
- If the client is chronically street homeless and open to placement into a Safe Haven, the Outreach Team will make all attempts to find an open bed, subject to availability. There is no assurance that a chronic street homeless client exiting an HCF will find a Safe Haven bed available.
- The Outreach Team will notify the HCF as soon as they determine whether a client will be placed. If a placement has been identified, Outreach may coordinate transportation from the HCF to the Safe Haven site, if needed.
- On the day of discharge, the HCF will email the updated Referral Form to the Outreach Team as a follow-up to the initial Referral Form and will include the client's:
  - Current discharge diagnoses;
  - Current medication list; and
  - Outpatient follow-up appointment(s) date and time.

- Safe Havens are specifically for chronically street homeless persons, meeting the following criteria: an individual has been living on the streets for a minimum of 9 of the last 24 months. This information can be verified in a number of ways: if the person stays at a particular location and a shop owner assists in determining how long the person has been at that location on the street; as per the DHS and HCF databases for homelessness history; or by a medical professional verifying length of homelessness.
- If a client is going to a Safe Haven placement, the HCF will call the Outreach within the timeframe stated on page 3 to coordinate the time of pick-up, as needed, once cleared for discharge by the outreach provider.
- If the client's health deteriorates right away at the placement site, or if the program observes that the individual is medically or psychiatrically inappropriate upon arrival, but does not meet the threshold for an EMS call, the Outreach Team will contact their medical provider and notify the DHS Program Administrator.
- If the Outreach Team medical provider determines that the client is medically inappropriate, they will contact the HCF social worker to discuss the case and as needed, make plans for transporting the client to the referring HCF with a warm handoff. If the HCF refuses to accept the client, the DIC will accept the client temporarily until the situation can be sorted out with the HCF.
- The DHS OMD will be informed as needed.
- Once the client is transported back to the HCF, the Outreach Team Medical Provider will keep close contact with the HCF.

- If the intervention of DHS OMD is necessary, the Outreach Medical Provider will notify the Program Administrator. As needed, a case conference between the HCF staff, the Outreach Team staff and medical provider, and the DHS Medical Director or designee may be scheduled by the Program Administrator.
- The Outreach Team will upload the Referral Form into the DHS Data System Document Repository for continuity of care and enter the requisite information in the client record.

A client should never be discharged to the street or a Drop-in Center under any circumstances.

Referrals of Clients from a Safe Haven

For referral of clients who were in a Safe Haven facility within the past year, the HCF will follow the process outlined below.

- The HCF will call the **DHS Referral Line at 212-361-5590** to determine the location and contact information of appropriate Safe Haven.
- The HCF will submit a complete Referral Form to the Safe Haven of record.
- The Safe Haven staff will review the referral in the timeframe stated on page 3.
- If the Safe Haven staff determines that the client is medically appropriate for discharge, the HCF will be contacted within the appropriate timeframe to confirm appropriateness for discharge.
- Once this determination has been made, or if the timeframe has past and the Safe Haven has not responded, the HCF will call the Safe Haven to determine if there is a bed available for the client.
- The HCF will work with the Safe Haven to coordinate the discharge.
  - If a bed is available in the coming days, the HCF will coordinate discharge with the Safe Haven medical provider and staff.
  - If a Safe Haven bed is not available, the Safe Haven staff will work with the DHS Street Solutions Division to coordinate placement. The HCF will be asked to hold the client for a mutually agreed time if possible while this coordination is taking place. In the meantime, the HCF will continue to urge the client, sensitively and carefully, to come into a traditional shelter.
- The Safe Haven staff will upload the Referral Form into the DHS Data System Document Repository for continuity of care and enter the requisite information in the client record.
- If, after discussion with the HCF, it is discovered that the HCF discharged a client knowing that they are inappropriate for shelter, OMD will send a complaint to:
  - The New York State (NYS) Department of Health or the NYS Office of Mental Health;
  - Greater New York Hospital Association (GNYHA); or the appropriate Nursing Home Association; and
  - HCF leadership.

Referrals of Clients from Long-Term Care Facilities

Except under special circumstances, residents of LTCFs who were admitted for long-term care have a significant likelihood to be unfit for shelter or Safe Haven. Given the typical length of stay in a LTCF, their staff are expected to work with homeless clients to apply for permanent housing for those who expect to recover and function independently. HRA has a number of resources to assist facility staff, see Appendix 4 (**DHS-14c**). DHS will review the Referral Form and make a determination of medical appropriateness within the timeframe stated on page 3.

- Clients receiving short term care in a LTCF who were previously in shelter can be referred back to shelter, following the *Process for Referral of Single Adults from Healthcare Facilities to the DHS Single Adult Shelter System*, Referrals of Clients who are Returning to a DHS Shelter, starting on page 15.
- The LTCF is required to provide complete discharge planning and include a summary of those efforts on the Referral Form.

Housing history and application

- The LTCF will perform a thorough housing history and update the history every three months for the duration of the client's stay and whenever the client indicates that there is a change.
- Family reunification assistance, if so desired by the client, should be facilitated by the LTCF.
- The LTCF is expected to assist their clients to avoid homelessness by taking advantage of resources from HRA including rental assistance, supplemental income, or legal services (Appendix 4 [**DHS-14c**]).
- In addition, the LTCF will assist the resident in enrolling into a Managed Long Term Care Plan.

Circumstances where referral to shelter or Safe Haven may be permitted

- The client was in short-term care for a temporary condition; **or**
- The condition has resolved and the client is independent in ADLs as per the DHS ADL Assessment (including able to follow-up with care recommendations and medication administration); **and**
- Housing applications have been made and have been unsuccessful; **and**
- The client agrees to shelter placement.

Referral Procedure

- After all efforts at finding permanent housing have been exhausted and unsuccessful, LTCF staff will complete the Referral Form, including documenting all housing efforts.
- The Referral Form will be emailed to DHS as follows:
  - **Clients new to DHS**
    - For women: HCFReferral@helpusa.org; and
    - For men: HCF-DHSReferral@dhs.nyc.gov.
  - If a client was a DHS client within the last 12 months, the LTCF will call the **DHS Referral Line at 212-361-5590** to obtain shelter or Safe Haven information.
- Attach a recent PRI, and SCREEN if applicable. DHS reserves the right to request documents necessary for the determination of medical appropriateness for shelter.

- The appropriate DHS facility, Intake Site or OMD will review the completed Referral Form to determine if the client is medically appropriate.
- If the client is medically appropriate and all housing efforts have been made and failed, and are documented on the Referral Form, the referral will be approved.
- If the client is medically appropriate but efforts at securing housing are insufficiently documented, additional documentation will be requested.
- The LTCF will be informed of the determination within the timeframe stated on page 3.
- If a client is sent to a DHS facility without a prior Referral Form and is found medically appropriate for shelter on arrival, the shelter will accept and provide a bed to the client. However, DHS OMD will be informed and a complaint will be sent to the LTCF.
- If the client is sent by a LCTF without a Referral Form and is confirmed to be medically inappropriate for shelter on arrival, or a LTCF sends a client to DHS despite notification by DHS that the client was medically inappropriate, the client will be transported to the HCF of origin after shelter staff communicate with the HCF social worker and via warm handoff.
- If the HCF refuses to accept the client after discussion with DHS, the shelter will accept the client while further discussions occur.
- The DHS facility medical provider or DHS OMD, as appropriate, will contact the HCF to report and discuss the occurrence. If, after discussion with the HCF, it is discovered that the HCF discharged a client knowing that they are inappropriate for shelter, OMD will send a complaint to:
  - The New York State (NYS) Department of Health or the NYS Office of Mental Health;
  - Greater New York Hospital Association (GNYHA); or the appropriate Nursing Home Association; and
  - HCF leadership.

SUMMARY OF ROLES AND RESPONSIBILITIES

DHS Office of the Medical Director

- Oversee and update the referral procedure.
- Provide training and technical assistance on the procedure to DHS staff.
- Review referrals and make determinations regarding medical appropriateness for shelter for men new to DHS[8] and respond to the HCF within the stated timeframe.
- Provide clinical consultation on cases and make recommendations.
- Provide training to HCF staff and as needed discuss cases with HCF staff (for shelters with medical providers, OMD will consult with HCF staff after the shelter medical provider has attempted to manage the situation).
- Advocate with HCF in the best interests of clients.
- Upload the Referral Form into the DHS Data System for single adult men who are new to the DHS shelter system.
- Track referrals and determinations.

DHS Program Administrators

- Ensure that intake, shelter, and Safe Haven staff follow referral procedures.
- Alert DHS OMD when assistance is needed for a client who appears medically inappropriate for shelter and there is no medical provider on-site.
- Communicate with shelter and Safe Haven staff.
- Facilitate shelter and Safe Haven admission and transfers.
- Track referrals and determinations.

Intake, Shelter, Safe Haven, and Drop-in Site Staff

- Review referrals for medical appropriateness for all returnees and women who are new to the DHS Single Adult Shelter System.
- Assessment sites will review new referrals for men and women upon arrival at an assessment site, for awareness of medical needs for new clients.
- Respond to the HCF within the stated timeframe.
- Evaluate clients and alert the site medical provider, call 911, or arrange transport of clients to the hospital, as needed.
- Follow-up with the HCF during client admission/placement and communicate with HCF regarding clients who were placed/returned to their site.
- Be available to HCF to discuss client and discharge planning in a timely manner.
- Plan discharge and transfer to site in collaboration with the HCF.
- If a site has a medical provider, that medical provider staff (medical professional or social work staff) will maintain communication, including clinical discussions about treatment and management with HCF, about clients.
- Alert Program Administrator when assistance from DHS OMD is needed, after the site has communicated with the HCF and was unable to resolve an issue.
- Track referrals and determinations.

[8] Referrals for women who are new to the shelter system are reviewed at the two women's intake and assessment sites

Health Care Facilities & Long Term Health Care Facilities

- Never send a client to shelter without a completed Referral Form and approval from DHS.
- Perform a complete housing history based on information provided by the client.
- Assist residents/clients in avoiding homelessness by exploring and documenting all attempts to locate available housing options and obtaining consent from clients/residents to communicate with HRA and work with HRA on housing applications.
- Complete all applications and referral documentation as required and wait to discharge clients to the shelter system for either a confirmation of approval by DHS or after the stated timeframe has passed (1 business data for LOS<30 days and 2 business days for LOS=>30 days).
- Begin discharge planning and coordination with DHS facilities early in the inpatient stay.
- Assist client in enrolling into a Health Home, if eligible.
- Assist client in identifying their managed care organization and a primary care provider (Appendix 7 [**DHS-14e**]).
- Complete SPOA and HRA 2010e applications, where needed and applicable.

- Ensure that all necessary follow-up care, both long and short-term, is scheduled and the client has the ability to travel to the appointments, or making arrangements so the client can attend appointments. Follow-up should include exact dates and times. Referrals to walk-in clinics or urgent care are unacceptable.
- Arrange for nurse visits where required and note this information on the Referral Form.
- Arrange for the client to pick-up or have medication prescriptions filled (particularly crucial for clients without Medicaid or other insurance). A minimum of two weeks prescription supply must be given to the client upon discharge from the HCF, unless otherwise directed by the client's primary care provider.
- Provide or arrange to provide client with all durable medical equipment such as a wheelchair, walker, or cane.
- Only consider shelter as a place for discharge under exceptional circumstance for those new to shelter.

APPENDICES

1. HCF-DHS Referral Form (**DHS-14**)
2. DHS ADL Assessment For Institutional Referrals (**DHS-14a**)
3. Housing Status Assessment Tool For Healthcare Providers (**DHS-14b**)
4. HRA Resources For Client Housing And Fact Sheet On “How To Find Help To Stay In Your Home” (**DHS-14c**)
5. Reasonable Accommodation Request Form (**DHS-13**)
6. Contact Information For DHS Outreach Teams (**DHS-14d**)
7. Federally Qualified Health Centers Resources (**DHS-14e**)

Client Name (First, Last): **LOS >30 days: Yes No** **DOB:**

HCF-DHS REFERRAL FORM
Screening Tool for Referral from Health Care Facilities: SINGLE ADULT

This HCF-DHS Referral Form must be completed for each patient who is admitted to a healthcare facility (HCF) or a long-term care facility (LTCF) and is being referred to the DHS Single Adult Shelter or Street System. Completion of this form for each patient will help Department of Homeless Services (DHS) to determine if:

(1) The patient is medically appropriate to reside in a single adult DHS shelter or Safe Haven facility; and

(2) All efforts have been made first to discharge the patient to a non-shelter setting.

Shelters for single adults are congregate settings with open dormitory-style rooms and do not provide nursing services; there are **no medical or respite shelters in the New York City DHS Shelter System.**

- For detailed guidance on this form, including a brief description of DHS and coordination of care guidance, see the *Referral from Healthcare Facilities to DHS Single Adult Facilities*, (hereafter referred to as the procedure) found at: https://www1.nyc.gov/site/dhs/shelter/singleadults/single-adults-hospital.page.
- Electronically completed forms are best practice, and DHS will review all received forms sent via email.
- Determinations regarding referrals or requests for more information will be communicated via email.
- If a homeless patient leaves against medical advice, please email **HCF-DHSreferral@dhs.nyc.gov.**
- This is a PDF fillable form and must be **electronically completed and submitted.** Forms that have been handwritten and/or faxed will not be accepted.

To use this form:

1- Call the DHS Referral Line at 212-361-5590 to determine if the patient is a new or current DHS client.
   a. If the patient is a current DHS client, the HCF will request the name of the client's assigned DHS site and the email address to which the referral form should be sent. The shelter director of the patient's assigned site.
   b. If the patient is new to the DHS system or has been out of shelter for over 12 months, email the form to:
      1. DHS-HCFreferral@dhs.nyc.gov for men, and
      2. HCFReferral@helpusa.org for women.

2- Complete the form and email it to the appropriate email address.

3- After the form has been sent via email, the DHS site or Office of the Medical Director will respond with a determination within 1 business day for inpatient stays less than 30 days and 2 business days for inpatient stays of 30 days or more.

Appendix 1

Client Name (First, Last): **DOB:**

Absolute Exclusion Criteria for DHS single adult shelter or safe haven If the patient has one or more of the health conditions, limitations of independent activities, or functional needs listed below, they are medically inappropriate for DHS single adult shelter or Safe Haven	
• Inability to care for self and independently manage activities of daily living; use the ADL Assessment Form included on the Referral Form. An ADL score <12 indicates medical inappropriateness for shelter. The ADL Assessment Form must be completed by a clinician on the patient's team; • Lack of decisional capacity; • Need for home care or visiting nurse services beyond wound care or IM/IV medication administration and beyond 2 weeks; • Severe immunosuppression (chemotherapy, end-stage AIDS, post-transplant, with an Absolute Neutrophil Count (ANC) <500mL); • Major dementia with cognitive deficits (MMSE <25); • Peritoneal dialysis; • Inability to make needs known or follow commands; • Unresolved delirium;	• Inability to independently manage chronic illnesses or medication administration, schedule, and reminders, including inability to self-administer insulin; • Inability to independently manage urinary catheters; • Inability to manage urinary or bowel incontinence or explosive diarrhea; • Oxygen-dependence requiring an oxygen tank/cylinder of any size, containing liquid or compressed oxygen (oxygen concentrators are allowed); • Cranial Halo Devices or stabilizing protective gear worn continuously; • Poses imminent risk of physical harm to themselves or others; • Inability to: understand spoken, signed, visual, or tactile language with or without an interpreter; or • On a ventilator.

If the patient has any of the health conditions, limitations of activities, or functional needs listed on this page STOP, the patient is medically inappropriate for a DHS shelter or Safe Haven and should not be sent to DHS. For more information on alternative housing solutions, please go to: https://www1.nyc.gov/site/hra/help/homelessness-prevention.page.

Relative Exclusion Criteria for DHS single adult shelter or Safe Haven If one or more of the following apply to the patient, the HCF/LTCF may be contacted for additional information by the DHS Office of the Medical Director or relevant site.	
• Requires infusion pumps/ PICC lines	• Intra-muscular or intra-venous medication administration via nurse- no more than twice per day, must be prearranged by HCF and limited to no more than 2 weeks
• Colostomy bag	
• Tracheostomy/ feeding tube	

Appendix 1

Client Name (First, Last): **DOB:**

FOR DHS SITE/OMD USE ONLY	
Reviewer name:	CARES number:
Gender:	SSN:
DOB:	HCF of origin:
Date and time review completed:	Destination shelter/ Safe Haven:
Does the client appear to need a reasonable accommodation? _____	Has the HCF requested a reasonable accommodation? _____
Status of referral:	Additional information needed:
If follow up referral, number of requests for information for this client:	Date/ time additional information requested:
Person information was requested from:	
If patient was medically inappropriate or more information needed, reason why:	

POST ARRIVAL AT DHS SITE	
Date patient arrived at shelter: Arrived,	
in worse state than described in referral ☐	despite determination of medical inappropriateness ☐
medically inappropriate and was transported back to healthcare facility ☐	within 24 hour period of referral being sent ☐
at shelter outside of the hours between 9:00am and 3:00pm ☐	medically inappropriate and was kept in shelter until situation resolved ☐

Healthcare facility staff please begin form here:

Name of healthcare facility:	**Type of HCF:** _____
Name of primary person completing this form: Title: Email Address: Telephone/beeper:	First alternate Email address: Telephone/beeper: Second Alternate Email address: Telephone/beeper:
Date this form was completed:	**Date of Admission:**
<30 day length of stay Yes No	**Expected Date of Discharge:**

Appendix 1

Client Name (First, Last): **DOB:**

Section 1. Patient Demographic and Healthcare Facility Information

1.1	**Alias(es)**	**CARES # (if known)**
	Date of Birth:	**Facility MRN:**
	Insurance type:	**Insurance #:**
	Ethnicity:	**Social Security #:**
	Race: _____ Other ☐ specify:	
	Gender: Other ☐ specify:	
	Patient agrees to be placed in shelter if found medically appropriate: Yes No Not Yet	

To ensure that all DHS shelter/Safe Haven referrals are independently able to complete all activities of daily living, indicate the DHS ADL assessment (page 5) score below.

DHS ADL Assessment Score: 0

If the patient scores less than 12 on the DHS ADL Assessment Form, they are inappropriate for shelter.

1.2	Healthcare facility name: Department or Service: _____ Telephone number:	
	Inpatient Physician Name: Telephone: Email:	Social Worker Name: Telephone: Email:
	Primary Care Physician Name: Telephone: Email:	Care Coordinator Name: Telephone: Email:

1) **Call the DHS Referral Line at 212-361-5590** to inquire if patient is known to DHS. You will be given the pertinent email address where the referral should be sent. If there is no answer, please leave a voicemail and someone will return your call as soon as possible.
2) If the patient has been in shelter in the last 12 months, go to Section 3 (skip Section 2).
3) If the patient is new to the DHS System or has not been in shelter in the past 12 months, go to Section 2.

1.3	Is patient new to DHS or have they not been in shelter within the past 12 months? YES NO	
	If the patient has been in a Single adult shelter in the past 12 months, please identify the patient's shelter of record:	

Appendix 1

Client Name (First, Last): **DOB:**

DHS ADL Assessment for Institutional Referrals

To be completed by healthcare facility staff only

Patient Name:	**Patient date of birth:**
Name and title of the person completing this assessment:	**Date:**

Scope	**The patient is able to…**	**Yes (1)**	**No (0)**
BATHING	Bathe self independently. May use devices such as shower chair and/or grab bars.		
DRESSING	Independently retrieve all clothing, dress, and undress, including shoes and outer garments.		
GROOMING	Groom self independently including shaving, brushing teeth and hair, and other common grooming activities.		
TOILETING	Successfully complete toileting independently including transferring and without supervision, preventing soiling of clothing and using toilet paper. May use raised toilet and/or grab bars.		
BOWELS	Manage bowels, catheter, colostomy bag, or diapers independently and without leaks.		
BLADDER	Control bladder functions without assistance, can include use of diapers to control leaking or minimal incontinence.		
TRANSFERRING	Independently transfer from wheelchair to bed and vice versa. May use elevated bed.		
FEEDING	Feed self independently, including for example carrying food tray, opening common food and drink containers, and cutting up own food.		
MOBILITY	Independently ambulate or use a cane, walker, or propel a manual or motorized wheelchair.		
COMMUNICATION	Communicate through spoken, signed, visual, or tactile language with or without an interpreter.		
COGNITION	Understand directions and follow commands, and make needs known.		
SELF-MANAGEMENT	Manage key responsibilities associated with independent living including medications and chronic illness(es).		

Total points from answers. If score is <12, patient is not appropriate for shelter.	**Total Score:**	0

Appendix 1

Client Name (First, Last): **DOB:**

Section 2. Housing History for New Clients of the Single Adult Shelter System

Prior residence, before current admission The HCF/LTCF must make all efforts to place patient in permanent housing before making a referral to DHS.			
2.1	☐ Home: rental/own/lease holder/ lived with partner or spouse	Residential facility: ☐ Adult Home ☐ Skilled nursing facility	☐ State psychiatric hospital, name:
	☐ Single Room Occupancy (SRO)	☐ Residential drug treatment facility ☐ OMH residential mental health facility	☐ Prison, name:
	☐ Aged out of foster care	☐ Rehabilitation center	☐ Jail, name:
	☐ Lived in friend's or relative's home	☐ Assisted living, other:	☐ Other, Specify:
2.2	Was the patient street homeless? Yes No		
2.3	If street homeless, length of stay in streets in past year if known/applicable: ☐ Unknown Usual locations, if known/applicable: ☐ Unknown		
2.4	Was the patient's prior living situation in another city/state/country? Yes No - If yes, specify city and state: - If yes, was patient staying in a homeless shelter? Yes No		
2.5	Length of stay at last location What has changed at last residence to prevent patient from returning?		
2.6	For those who meet Adult Protective Services (APS) (https://www1.nyc.gov/assets/hra/downloads/pdf/services/aps/APS_BROCHURE.pdf), is the patient under the care of APS? Yes No		
2.7	**Reasons patient is homeless:**		
	☐ Lost employment	☐ Evicted/ other reasons	
	☐ Divorce/ separation	☐ Evicted/ did not pay rent	
	☐ Domestic violence	☐ Aged out of foster care	
	☐ Recently released from jail, prison, or other criminal justice institution	☐ Other, specify:	

Appendix 1

Client Name (First, Last): **DOB:**

Housing applications: As applicable, detail the efforts that were made to assist the patient in securing a return home or another non-shelter setting based on housing and clinical history. Please provide outcomes and list all efforts: attempted, reason failed, or ineligible.

2.7	**Potential Housing**	**Attempted: date**	**Reason Failed**	**Not eligible**	**N/A**
	Relative's or friend's home				
	Return to own home				
	Adult home				
	Skilled nursing facility				
	Sub-acute unit				
	Rehabilitation center				
	Residential drug treatment facility				
	OMH residential mental health facility				
	Assisted living, other:				
	SRO				
	Applied for rental assistance				
	Applied for other subsidies/ rental assistance with HRA				
	HASA services (if eligible)				
	Voluntary diversion to residence outside NYC				
	Other, specify:				
	Please indicate reasons why the patient is ineligible for all non-shelter housing options:				

Please include housing applications submitted and any available documentation thereof.
An HRA 2010e application for supportive housing should ideally be made prior to discharge for potentially eligible patients.

Client Name (First, Last): **DOB:**

Section 3. Clinical Information

Reason for admission: ***Indicate the principal reason for admission. If reason is not listed, please specify other reason for admission in text box labelled "Specify other reason for admission."***

3.1	☐ Chronic Disease	☐ Accident or injury	☐ Psychiatric distress
	☐ Substance use	☐ Alcohol intoxication	☐ Suicidal ideation
	☐ Homicidal ideation	☐ Suicide attempt	☐ Acute illness
	☐ Other, specify:		

3.2 Was the patient admitted for violent or threatening behavior? Yes No

If yes:

1. Was the patient compliant with medications while in the healthcare facility? Yes No
2. Does the patient have insight related to their mental illness? Yes No
3. Does the patient have insight into their need to be compliant with medications upon release? Yes No
4. Date of last known episode of violence:
5. Date of last emergency injection (if applicable):

3.3 Does the patient have a known history of arson? Yes No

3.4 In past 12 months prior to this admission, self-reported number of:

Hospital stays: None ☐ 1 or more, approximate number:

ED visits: None ☐ 1 or more, approximate number:

3.5 DISCHARGE DIAGNOSES: Indicate all medical and mental health diagnoses:

MEDICAL		
Arthritis or other joint disease	Yes ☐	No ☐
Cancer	Yes ☐	No ☐
Type of cancer:	ANC #:	
Chronic kidney/renal disease	Yes ☐	No ☐
On dialysis	Yes ☐	No ☐
Chronic liver disease	Yes ☐	No ☐
Cirrhosis	Yes ☐	No ☐

Appendix 1

Client Name (First, Last): **DOB:**

Hepatitis B	Yes ☐	No ☐
Hepatitis C	Yes ☐	No ☐
Chronic pulmonary disease	Yes ☐	No ☐
COPD	Yes ☐	No ☐
Emphysema	Yes ☐	No ☐
Asthma	Yes ☐	No ☐
Chronic bronchitis	Yes ☐	No ☐
Cognition (not related to a Developmental Disability, specify):		
Delirium	Yes ☐	No ☐
Dementia (any form)	Yes ☐	No ☐
MMSE score:		
Diabetes- insulin dependent	Yes ☐	No ☐
Able to self-administer insulin?	Yes ☐	No ☐
Head injury or trauma	Yes ☐	No ☐
Heart Disease	Yes ☐	No ☐
Heart failure	Yes ☐	No ☐
Class IV:	Yes ☐	No ☐
HIV/AIDS	Yes ☐	No ☐
CD4 count		
HASA referred	Yes ☐	No ☐
Hypertension	Yes ☐	No ☐
Immuno-suppressed	Yes ☐	No ☐
ANC score:		
Incontinence (urinary or bowel)	Yes ☐	No ☐
Recent surgery	Yes ☐	No ☐
Type of surgery:		
Seizure disorder/ epilepsy	Yes ☐	No ☐
DEVELOPMENTAL DISABILITY		
Does the patient have a diagnosis of, or if there reason to believe they have a diagnosis of a developmental disability (or show signs of):		
Autism Spectrum Disorder	Yes ☐	No ☐
Cerebral Palsy	Yes ☐	No ☐
Intellectual disability (formerly known as Mental Retardation)	Yes ☐	No ☐
Neurological Impairment	Yes ☐	No ☐
Seizure Disorder (before age 22)	Yes ☐	No ☐
Any diagnosis that manifests similarly to Intellectual Disability	Yes ☐	No ☐
BEHAVIORAL HEALTH		

Appendix 1

Client Name (First, Last): **DOB:**

	Mental health:		
	Anxiety disorder	Yes ☐	No ☐
	Bipolar disorder	Yes ☐	No ☐
	Depression	Yes ☐	No ☐
	Obsessive-Compulsive Disorder	Yes ☐	No ☐
	PTSD	Yes ☐	No ☐
	Schizoaffective Disorder	Yes ☐	No ☐
	Schizophrenia	Yes ☐	No ☐
	Substance and Alcohol use:		
	Substance use	Yes ☐	No ☐
	Specify drug:		
	History of non-fatal overdose	Yes ☐	No ☐
	Date *if known*:		
	Other conditions not listed above:		

If a cognitive impairment is indicated, please send a complete MMSE with this Referral Form.

Appendix 1

Client Name (First, Last): **DOB:**

Section 4. Functional Status

For patients with a disabling condition due to a medical condition or disability, please attach a completed DHS Reasonable Accommodation Request Form (https://www1.nyc.gov/assets/dhs/downloads/pdf/client-accom-request-form.pdf) when this Referral Form is submitted. For example, but not limited to: gastrostomy tube, tracheostomy/feeding tube, requires infusion pumps or picc lines, colostomy bag, needs wound care or nursing visits, or uses a wheelchair, walker, cane or crutches, CPAP or BiPAP/ BPAP machine, or oxygen concentrator.

For additional guidance, see the *Process for Referral of Single Adults from Healthcare Facilities to the DHS Single Adult Shelter System.*

Please attach PRI if patient is being referred from a Long Term Care Facility and those hospitalized for > 2 months.

4.1	**Health conditions, limitations of independent activities, and functional needs:**			
	Urinary catheter	Yes ☐	No ☐	N/A ☐
	Urostomy bag	Yes ☐	No ☐	N/A ☐
	If yes to any diagnosis or possibility of diagnosis to developmental disability listed in section 3.5:			
	Did any of the following codes appear in eMedNY/ePACES: 44,45,46,49, and 95?		Yes ☐	No ☐
	Was OPWDD contacted?		Yes ☐	No ☐
	Indicate which codes appear and what the outcome of the conversation was with OPWDD:			
	Gastrostomy tube	Yes ☐	No ☐	N/A ☐
	Tracheostomy/feeding tube	Yes ☐	No ☐	N/A ☐
	Intra-muscular or intra-venous medication administration via nurse- no more than 2 per day, must be prearranged by HCF and limited to no more than 2 weeks	Yes ☐	No ☐	N/A ☐
	Requires infusion pumps/ PICC lines	Yes ☐	No ☐	N/A ☐
	Colostomy bag	Yes ☐	No ☐	N/A ☐
	Unable to walk more than a few feet alone	Yes ☐	No ☐	N/A ☐
	History of accidents or leaks	Yes ☐	No ☐	N/A ☐
	History of falls	Yes ☐	No ☐	N/A ☐
	Wound care	Yes ☐	No ☐	N/A ☐
	Number of dressing changes per day: _____			N/A ☐
	Able to manage wound dressing alone	Yes ☐	No ☐	N/A ☐
	Nursing Service	Yes ☐	No ☐	N/A ☐
	Estimated number of visits per day:			
	Describe function:			
	Arranged?	Yes ☐	No ☐	N/A ☐

Appendix 1

Client Name (First, Last): **DOB:**

	Please arrange nursing visits for first thing in the morning before shelter clients have left the premises.			
	Contact Name:	Phone number/Email:		
	Estimated number of weeks of VNS required:			
	Can the patient communicate via any method (interpreter, spoke, written, tactile, etc.)?	Yes ☐	No ☐	N/A ☐
4.2	**Durable Medical Equipment:**			
	Wheelchair	Yes ☐	No ☐	
	Walker	Yes ☐	No ☐	
	Cane or crutches	Yes ☐	No ☐	
	CPAP or BiPAP machine	Yes ☐	No ☐	
	Oxygen concentrator	Yes ☐	No ☐	

	Medications list: Please list all discharge medications for the patient. If unable to include medication list here, please attach a medications list *only* as an attachment to this form.
4.3	

	Comments: Please include any relevant information that DHS site staff or OMD should be aware of regarding the patient, reasons for admission, discharge, or care coordination.
4.4	

Appendix 1

Client Name (First, Last): **DOB:**

Section 5. Discharge Plans

- Please indicate below if follow-up plans are still being arranged and email to the relevant site all follow up plans as early as possible and at the latest, by the day of discharge.
- Referrals must include planned follow-up care including a primary care physician appointment.
- If the client is on AOT or an ACT team, please submit a Reasonable Accommodation form for a location-based placement.

5.1 Follow-up plan:

Are follow-up care appointments still being arranged?			Yes ☐ No ☐	N/A ☐
Are follow-up plans attached to this form?			Yes ☐ No ☐	N/A ☐
Medical appointment	Date	Time	Location	N/A ☐
Contact Name:		Phone number/Email:		
Mental health appointment	Date	Time	Location	N/A ☐
Contact Name:		Phone number/Email:		
Substance use services	Date	Time	Location	N/A ☐
Contact Name:		Phone number/Email:		
Surgical follow-up	Date	Time	Location	N/A ☐
Contact Name:		Phone number/Email:		
Physical therapy initial appointment	Date	Time	Location	N/A ☐
Contact Name:		Phone number/Email:		
Other appointment (1):	Date	Time	Location	N/A ☐
Contact Name:		Phone number/Email:		
Other appointment (2):	Date	Time	Location	N/A ☐
Contact Name:		Phone number/Email:		
Application made for Health Home		Yes ☐	No ☐	N/A ☐
Health Home care coordinator	Name:			N/A ☐
Telephone:		Email:		
AOT order application done			Yes ☐ No ☐	N/A ☐
If yes, was final court order and treatment plan received?			Yes ☐	No ☐
If no, does the patient not meet criteria? Specify:				
Is the patient on ACT team?			Yes ☐ No ☐	N/A ☐
Name of ACT team:		Borough of ACT team:		
ACT team contact name and phone number/email:				

Appendix 1

Client Name (First, Last): **DOB:**

Section 6. Treatment Team Approval

In the opinion of the clinical treatment team, the patient is independent (does not require support or assistance) in activities of daily living as detailed in the DHS ADL Assessment for Institutional Referrals on page 5, and the patient:

- Will be able to function in shelter in a congregate setting and without home care or long term nursing support; and
- Has no health, mental, or emotional concerns that may make them a danger to themselves or others in a shelter setting.

If one or both of the above statements are false, the patient is inappropriate for shelter.

We, the treatment team identified below, hereby attest to the truth of the above statements, and that everything included in this HCF-DHS Referral Form is a true and accurate representation of the health conditions, limitations of independent activities, and functional needs of the patient. We explored non-shelter housing options to the best of our abilities and confirm that no viable and safe alternatives to shelter were found prior to making this referral to DHS.

Treating Provider

Name	Title
Telephone	Email

Social Worker

Name	Title
Telephone	Email

Member of treatment team

Name	Title
Telephone	Email

Appendix 2

Department of Homeless Services
Department of Social Services

DHS-14a (E) 06/22/2018

DHS ADL ASSESSMENT FOR INSTITUTIONAL REFERRALS

TO BE COMPLETED BY HEALTHCARE FACILITY STAFF ONLY

Patient Name _____ **Patient Date of Birth** _____

Name and Title of the person completing the assessment _____ **Date** _____

SCOPE	THE PATIENT IS ABLE TO….	YES (1)	No (0)
BATHING	Bathe self independently. May use devices such as shower chair and/or grab bars.		
DRESSING	Independently retrieve all clothing, dress, and undress, including shoes and outer garments.		
GROOMING	Groom self independently including shaving, brushing teeth and hair, and other common grooming activities.		
TOILETING	Successfully complete toileting independently including transferring and without supervision, preventing soiling of clothing and using toilet paper. May use raised toilet and/or grab bars.		
BOWELS	Manage bowels, catheter, colostomy bag, or diapers independently and without leaks.		
BLADDER	Control bladder functions without assistance, can include use of diapers to control leaking or minimal incontinence.		
TRANSFERRING	Independently transfer from wheelchair to bed and vice versa. May use elevated bed.		
FEEDING	Feed self independently, including carrying food tray, opening common food and drink containers, and cutting up own food.		
MOBILITY	Independently ambulate or use a cane, walker, or propel a manual or motorized wheelchair.		
COMMUNICATION	Communicate through spoken, signed, visual, or tactile language with or without an interpreter.		
COGNITION	Understand directions and follow commands, and make needs known.		
SELF-MANAGEMENT	Manage key responsibilities associated with independent living including medications and chronic illness(es).		

Total points from answers. If score is <12, patient is not appropriate for shelter. **Total Score:** _____

Appendix 3

Department of Homeless Services
Department of Social Services

DHS-14b (E) 06/22/2018

HOUSING STATUS ASSESSMENT TOOL FOR HEALTHCARE PROVIDERS

Please ask patient the following three questions to ascertain if they are homeless or may become homeless during their inpatient stay:

1. Where did you stay last night? (please match the patient's answer to the one that most closely matches below)

a. Emergency shelter, including hotel or motel voucher paid for by a social service or charitable organization
b. Transitional housing for homeless persons
c. Permanent supportive housing for formerly homeless persons
d. Psychiatric hospital or other psychiatric facility
e. Substance abuse treatment facility or other detox facility
f. Hospital (non-psychiatric)
g. Jail, prison, or juvenile detention facility
h. Half-way or three-quarter-way home for persons with criminal offenses
i. Room, apartment, or house that you rent or own
j. In a friend's or family member's room, apartment, or house
k. Foster care home or foster care group home
l. Group home or other supervised residential care facility
m. Place not meant for human habitation (street, car, park, etc.)
n. Other, please specify
o. Don't know
p. Refused

2. Can you return to this place upon discharge?

a. Yes
b. No

3. If No, is there other safe housing where you can stay upon discharge, or when you leave the place you are currently staying?

a. Yes
b. No

Appendix 4

Department of Homeless Services
Department of Social Services

HRA RESOURCES FOR CLIENT HOUSING AND FACT SHEET ON "HOW TO FIND HELP TO STAY IN YOUR HOME"

EMERGENCY RENT ASSISTANCE GRANTS:

Emergency grants may include rental assistance to prevent eviction; assisting with home energy and utility bills, and moving expenses. To apply, visit the nearest HRA Job Center. For more information call HRA's Infoline at 718-557-1399.

LEGAL REPRESENTATION FOR TENANTS FACING EVICTION:

HRA funds Anti-Eviction Legal Services in the housing courts and in community offices across the City. If someone needs legal help with an eviction, please find the Anti-Eviction Legal Services location nearest you by dialing 311.

RENTAL ASSISTANCE:

- Families with children**:** CITYFEPS Rent Supplement Program: http://www1.nyc.gov/site/dhs/permanency/cityfeps.page
- Single adults or households without minor children can qualify for the SEPS program: https://www1.nyc.gov/site/hra/help/legal-assistance.page. Households not currently in DHS or HRA shelter can also qualify if they meet the following criteria:
  - The applicant is a veteran
  - The applicant is getting evicted and has a shelter history, an APS case or a rent controlled apartment.

HOMEBASE HOMELESSNESS PREVENTION:

With conveniently located prevention centers staffed with homelessness prevention experts, Homebase offers a range of services under one roof, including services to prevent eviction and assistance obtaining public benefits: https://www1.nyc.gov/site/dhs/prevention/homebase.page.

(Turn page)

HOW TO FIND HELP TO STAY IN YOUR HOME

If you need help staying in your own home, the City has homelessness prevention and other services to assist you. The City also has services to help you move-out of shelter.

➢ LEGAL SERVICES FOR TENANTS

Are you a tenant facing an eviction in court? Is your landlord harassing or threatening you? Does your building refuse to make repairs? New Yorkers facing housing issues in court can get free legal help. If you qualify, we can connect you with a free lawyer who can:

- Assist you in court if you are facing eviction
- Sue a landlord who is:
  - Harassing you to move out
  - Not making repairs
  - Refusing to take your housing benefits
- Make sure your rent level is correct and take action if you are being overcharged
- Give you advice on your rights as a tenant

If you need legal help because you are being evicted or your landlord is harassing you or trying to displace you or your neighbors, **please call the City's Tenant Protection Hotline at 917-661-4505 or email civiljustice@hra.nyc.gov.**

➢ EMERGENCY RENTAL ASSISTANCE

The "One-Shot Deal" emergency assistance program helps people who cannot pay an expense due to an unexpected situation or event. Emergency assistance is provided for, but not limited to, expenses such as rent and utilities. **Contact HRA's Infoline at 718-557-1399 for more information about the One-Shot Deal.**

➢ HOMEBASE

HRA works with non-profit community organizations that operate Homebase homelessness prevention offices at 24 community locations across the City. Among the services they offer are:

- Assistance obtaining public benefits
- Emergency rental assistance
- Education and job placement assistance
- Financial counseling and money management
- Help relocating
- Short-term financial assistance

Call 311 to locate the nearest Homebase office.

➢ HELP LEAVING A HOMELESS SHELTER

If you are currently in a homeless shelter, speak with your case manager to learn more about what assistance is available to help you leave shelter, which may include rental assistance. If you have further questions about rental assistance, **call the Rental Assistance Call Center at 929-221-0043.**

Appendix 5

Department of Homeless Services
Department of Social Services

REASONABLE ACCOMMODATION REQUEST FORM

INSTRUCTIONS: Clients must complete Section I and submit this form along with supporting documentation to the Program/Facility Director, or functional equivalent ("Director"). Any Director receiving a completed form with appropriate medical documentation must complete Section II, return a copy to the client, and immediately transmit by facsimile the request and supporting documents to the appropriate Program Administrator, and the Office of Diversity & Equal Opportunity Affairs.

Section I: (This section must be completed by the client.)

Name: _____

Address/Facility/Program: _____

Social Security #: _____ Phone: _____

Describe the Accommodation Requested (attach additional sheets and supporting documentation as appropriate).

_____

_____

_____

_____

_____

Section II: (To be completed by the Director or his/her designee.)

Name/Title: _____

Facility/Program: _____

Address: _____

Phone: _____ Date Received: _____

Signature: _____

After completing this section, the Director must give a copy of this form to the client and immediately fax the request to the appropriate Program Administrator, Program Analyst and the Office of Diversity & Equal Opportunity Affairs, 33 Beaver Street, New York, New York 10004/Tel. 212-361-7914/ Fax. 212.361.7912/ TTY. 212-361-7915/ eoa@dhs.nyc.gov.

Appendix 5

Section III: (To be completed by the Program Administrator or his/her designee.)

Name/Title: _____

Phone: _____ Date Received: _____

Signature: _____

Detailed record of the accommodation review process, including but limited to: a description of medical documentation received; Director/Program Administrator comments; notes regarding consultations with DHS Medical Director and, as needed, Client Advocacy; proposed accommodations; final determination.

_____

_____

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Appendix 6

Department of Homeless Services
Department of Social Services

DHS-14d (E) 06/22/2018

CONTACT INFORMATION FOR DHS OUTREACH TEAMS

Bronx Outreach 24-hour number: Director: Juan Rivera	BronxWorks 718-893-3606 jrivera@bronxworks.org
Brooklyn/Queens Street to Home Program Directors:	Breaking Ground Brooklyn: Casey Burke 917-753-1837 Queens: Cara Ochsenreiter 613-875-4353
Manhattan Outreach Consortium 24-hour number Director: Erica Strang	Center for Urban Community Svcs 212-234-9631 212-801-3340 Office or estrang@cucs.org
Staten Island 24-hour number: Director: Teisha Diallo	Project Hospitality 347-538-2314 teisha_diallo@projecthospitality.org
MTA Outreach 24-hour number Director: Jose del Toro-Alonso	BRC 212-533-5151 jtoro@brc.org

Appendix 7

Department of Homeless Services
Department of Social Services

Federally Qualified Health Centers Resources

Started in 1996, The New York City Providers of Health Care for the Homeless (PHCH) is a coalition of homeless-serving Federally Qualified Health Centers (FQHC) in New York City. Each member receives grant funds from the federal Health Resources & Services Administration (HRSA) to provide healthcare services to homeless individuals and/or families. PHCH works in close partnership with the Community Health Care Association of New York State (CHCANYS) around advocacy, policy and common challenges in the rapidly changing healthcare environment.

In 2016, PHCH members served 64,421 homeless patients, of whom 5,844 were children. PHCH members have increasingly become the trusted provider of choice, delivering **high-quality medical, mental health and support services** in places where homeless people live or congregate. Through this specialized, population-focused mode of service delivery, providers are able to effectively address many of the health disparities that homeless patients face.

As one of the original pilot programs for the national Health Care for the Homeless program, New York was instrumental in establishing the foundational principles of innovative, integrated care, with an **ongoing emphasis on extensive outreach, prevention, and a unique understanding of the social determinants of health for homeless people.**

The members of PHCH operate **96 healthcare sites**, many of which are co-located with homeless shelters, allowing facilitated access to comprehensive healthcare for homeless patients. **In 2016, PHCH members provided 316,008 medical visits to homeless patients**. Some of the services provided by PHCH members include:

- Primary care
- Psychiatry
- Comprehensive behavioral health services
- Addiction treatment services
- HIV specialty care
- Women's health services
- Oral health services
- Podiatry
- Mobile healthcare
- Health education and counseling
- Pharmacy services
- Facilitated insurance enrollment
- Care management
- Benefits and entitlements assistance
- Full spectrum of prevention programs

By providing integrated, whole-person care to patients who are among the sickest, most underserved people in New York, PHCH is an essential part of the healthcare safety-net, and a leader in creating value in an extraordinarily complex and dynamic healthcare environment. For more information, please contact Aaron Felder at aaron.felder@projectrenewal.org.

(Turn Page)

Providers of Healthcare for the Homeless	
Organization Name & General Contact	**Location Name & Contact Information**
Brightpoint Health Call Center for All Health Clinics (855) 681-8700	1669 Bedford Avenue (location provides mental health services) Brooklyn, NY 11225
	1545 Inwood Avenue Bronx, NY 10452
	Sutphin Health Center 105-04 Sutphin Blvd Jamaica, NY 11435
Callen-Lorde Community Health Center	**Callen-Lorde Manhattan** 356 West 18th Street New York, NY 10011 (212) 271-7200
Care for the Homeless	**Citadel Medical Clinic** 90-23 161st Street Jamaica, NY 11432 (718) 709-5054
	Mobile Health Clinic Varies (212) 935-CARE (2273)
Convenant House	460 West 41st Street New York, NY 10036 (212) 613-0300
Harlem United	**Harlem United Medical Services** 179 East 116th Street New York, NY 10029 (212) 987-3707 M (9 AM -8 PM), Tu (1 PM - 5 PM), W (9 AM -5 PM), Th (9 AM -7 PM), Fr (9 AM -5 PM)
	Harlem United- The Nest 169 West 133 Street New York, NY 10030 (646) 762- 4950 Medical, Dental & Behavioral Health - Hours M-F (9 AM to 5 PM)
Housing Works	**Housing Works- East New York Community Health Center** 2640 Pitkin Avenue Brooklyn, NY 11208 (718) 277-0386

(Turn Page)

Providers of Healthcare for the Homeless	
Organization Name & General Contact	**Location Name & Contact Information**
ICL Healthcare Choices	**HealthCare Choices** 6209 16th Avenue Brooklyn, NY 11204 (718) 234-0073
The Family Health Centers at NYU Langone *http://nycfreeclinic.med.nyu.edu/patient-information/schedule-appointment*	**16 East 16th Street** **To schedule an appointment:** (212) 206-5200 Calls can be made Mon-Fri between 8 AM and 10 PM or Sat-Sun between 8 AM and 8 PM
New York Children's Health Project, a Program of The Children's Hospital at Montifiore & Children's Health Fund *Website: montekids.org*	853 Longwood Avenue Bronx, NY 10459 (212) 535-9779
Project Renewal	**@ Fort Washington Men's Shelter** 651 West 168th Street New York, NY 10032 (212) 740-1780 Offered to Shelter Residents: Primary Care, Dental and Optometry Services
The Floating Hospital (FH- 2 Queens Locations)	**FH Crescent Street Health Center** 41-43 Crescent Street (718) 784-2240 x107
	FH Queensbridge Health Center 10-29 41 Avenue Long Island City, NY 11101 (718) 361-6266
William F. Ryan Community Health Center	***Multiple Locations Throughout Manhattan*** General Appointment Number (212) 749-1820