

Client Name (First, Last):

DOB:

LOS over 30 days: Yes No

CARES ID:

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.

Facilities 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.**

Please note that if the form is incomplete, the DHS facility or Office of the Medical Director will contact you to request all missing information. This will delay the determination and approval.

- 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:
 - I. DHS-HCFreferral@dhs.nyc.gov for men, and
 - II. 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.

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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

<ul style="list-style-type: none"> • 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) <500/mL); • Major dementia with cognitive deficits (MMSE <25); • Peritoneal dialysis; • Inability to make needs known or follow commands; • Unresolved delirium; 	<ul style="list-style-type: none"> • 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; • On a ventilator; or • CD4 count below 200.
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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.

<ul style="list-style-type: none"> • Requires infusion pumps/ PICC lines 	<ul style="list-style-type: none"> • 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
<ul style="list-style-type: none"> • Colostomy bag 	
<ul style="list-style-type: none"> • Tracheostomy/ feeding tube 	

APPENDIX 1**Client Name (First, Last):****DOB:****CARES ID:**

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:	If additional information needed, date/ time additional information requested:
If follow up referral, number of requests for information for this client:	
Person information was requested from:	
If patient was medically inappropriate, reason why:	
If referral was incomplete, specify missing information:	
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: If not listed, please type:	Type of HCF:
Name of primary person completing this form:	First alternate Email address:
Title:	Telephone/beeper:
Email Address:	Second Alternate Email address:
Telephone/beeper:	Telephone/beeper:
Date this form was completed:	Date of Admission:
Over 30 day length of stay: Yes No	Expected Date of Discharge:

Client Name (First, Last):

DOB:

CARES ID:

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	
1.2	Healthcare facility name:	
	Department or Service:	
	Telephone number:	
	Inpatient Physician Name:	Social Worker Name:
	Telephone:	Telephone:
	Email:	Email:
1.3	Primary Care Physician Name:	Care Coordinator Name:
	Telephone:	Telephone:
	Email:	Email:
<p>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.</p> <p>2) If the patient has been in shelter in the last 12 months, go to Section 3 (skip Section 2).</p> <p>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.</p>		
1.3	Is patient new to Single Adult Shelter System or have they not been in a single adult 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:	

CARES ID:

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).		
If score is less than 12, patient is not appropriate for shelter.		Total Score:	

Client Name (First, Last):

DOB:

CARES ID:

Section 2. Placement Efforts for New Clients of the Single Adult Shelter System

Prior location, 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 Residential drug treatment facility OMH residential mental health facility Rehabilitation center Assisted living, other:	Street homeless
	Single Room Occupancy (SRO)		Prison, name:
	Aged out of foster care		Jail, name:
	Lived in friend's or relative's home		State psychiatric hospital, name:
Other, specify:			
2.2	If street homeless, length of stay in streets in past year if known/applicable:		Unknown
	Usual locations, if known/applicable:		Unknown
2.3	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
2.4	Length of stay at last location		
	What has changed at last residence to prevent patient from returning?		
2.5	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
2.6	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:	

Client Name (First, Last):

DOB:

CARES ID:

Placement efforts: As applicable, detail efforts made to assist the patient in securing a return home or another non-shelter setting based on housing and clinical history. Provide outcomes and list all efforts: attempted, reason failed, or ineligible. Please note that shelter is a last resort and healthcare facility staff are expected to exhaust placement efforts, and attempts must be documented for every eligible placement opportunity.

2.7	Potential alternate placement:	Eligible:		Attempted date:	Justify inability to place patient in alternate housing:
		Yes	No		
	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. HRA 2010e applications for supportive housing should be made prior to discharge for potentially eligible patients.

Client Name (First, Last):

DOB:

CARES ID:

Section 3. Clinical Information

Reason for admission: <i>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."</i>			
3.1	Accident or injury, specify:	Acute illness, specify:	Alcohol intoxication
	Chronic Disease, specify:	Homicidal ideation	Psychiatric distress, specify:
	Substance use, specify:	Suicide attempt	Suicidal ideation
	Other, specify:		
3.2	Please explain reason for admission:		
3.3	Hospital course: Please include information regarding the patient's hospital course including detailed reason for admission and other salient information.		
3.4	Was the patient admitted for violent or threatening behavior?		Yes No
	<u>If yes:</u>		
	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):		
3.5	Does the patient have a known history of arson?		Yes No
3.6	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:	

Client Name (First, Last):

DOB:

CARES ID:

3.7 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
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
Tuberculosis test:		
TST: Date:	Positive	Negative
QFN: Date:	Positive	Negative
Chest X-Ray date:		

Client Name (First, Last):

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Consistent with:			
• No active disease		Yes	No
• Old tuberculosis		Yes	No
• Active tuberculosis		Yes	No
• Suspicion for tuberculosis		Yes	No
Latent Tuberculosis:		Yes	No
Active Tuberculosis:		Yes	No
Treatment start date:			
Were 3 consecutive negative smears obtained*:		Yes	No
If yes*:	Date 1:	Date 2:	Date 3:
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			
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 <i>if known</i> :			
Other conditions not listed above:			

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

*Only applies to respiratory/pulmonary tuberculosis.

Client Name (First, Last):

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CARES ID:

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 3.7:			
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
4.2 Wound care	Yes	No	N/A
Location of wound:			
Size of wound:			
Cause of wound, if known:			
Number of dressing changes per day:			N/A
Able to manage wound dressing alone	Yes	No	N/A
4.3 Nursing Service	Yes	No	N/A
Estimated number of visits per day or per week:			

Client Name (First, Last):

DOB:

CARES ID:

	Describe function:			
	Arranged?	Yes	No	N/A
	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:			
4.4	Can the patient communicate via any method (interpreter, spoken, written, etc.)?	Yes	No	
4.5	Durable Medical Equipment:			
	Wheelchair	Yes	No	
	Walker	Yes	No	
	Cane or crutches	Yes	No	
	CPAP or BiPAP machine	Yes	No	
	Oxygen concentrator	Yes	No	

Client Name (First, Last):

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Section 5. Medication List and Relevant Information

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.

5.1

Comments: Please include any relevant information that DHS site staff or OMD should be aware of regarding the patient, to optimize shelter and service coordination.

5.2

Client Name (First, Last):

DOB:

CARES ID:

Section 6. Discharge Plans

- Please indicate below if follow-up plans are still being arrange and email plans to the relevant site
- All follow up plans should be made as early as possible and at the latest, by the day of discharge.
- Please check off all planned appointments if not made at time of referral submission.
- Referrals must include planned follow-up care including a primary care physician appointment.
- For clients on AOT or an ACT, submit a Reasonable Accommodation form for a location-based placement.

Follow-up plan:

6.1	Are follow-up care appointments still being arranged?	Yes	No	
	Are follow-up plans attached to this form?	Yes	No	
	Medical appointment	Date	Time	Location
	Contact name:			Phone number/ email:
	Mental health appointment	Date	Time	Location
	Contact name:			Phone number/ email:
	Substance use appointment	Date	Time	Location
	Contact name:			Phone number/ email:
	Surgical follow-up appointment	Date	Time	Location
	Contact name:			Phone number/ email:
	Physical therapy initial appointment	Date	Time	Location
	Contact name:			Phone number/ email:
	Other appointment (1):	Date	Time	Location
	Contact name:			Phone number/ email:
	Other appointment (2):	Date	Time	Location
	Contact name:			Phone number/ email:
6.2	Application made for Health Home	Yes	No	N/A
	Health Home care coordinator name:			
	Telephone:	Email:		
6.3	AOT order application complete	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:			
6.4	Does patient have an ACT team?	Yes	No	N/A <input type="checkbox"/>
	Name of ACT team:	Borough of ACT team:		
	ACT team contact name and phone number/ email:			

Client Name (First, Last):

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Section 7. 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

**PATIENT AGREEMENT TO DHS SHELTER DISCHARGE
FOR DHS SINGLE ADULT SHELTERS AND
STREET SOLUTIONS FACILITIES**

New Referrals ONLY

Healthcare Facility Name: _____

Patient's Name: _____

Name of Social Worker on the Case: _____

I, _____ agree to be discharged to a DHS shelter
(*name of patient*)
or Safe Haven. It has been explained that there is no other option for discharge at this time, or
I have rejected, when offered, the following placements:

I understand that most shelters and Safe Havens do not have on-site medical care and have
no 24-hour nursing care. I understand that I will have to be independent in all of my activities of
daily living.

I also understand that I may access the DHS shelter system without releasing my medical
information. I have a right to a signed copy of this form.

Hospital Representative Signature

Date

Patient Signature

Date