# Institutional Referral Process for Single Adults from Inpatient Departments of Healthcare Facilities to DHS Facilities

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NYC Department of Homeless Services
Department of Social Services

# Overview

1. Goals
2. Overview of Shelter System
3. The Referral Procedure
4. 2018 New Form Guidelines
5. Discharge Guidelines to Single Adult Shelters
6. The Referral Process
7. The HCF-DHS Referral Form
8. Resources for Healthcare Facilities
9. Identifying and Supporting Homeless Patients
10. Communication Between HCF and DHS Staff
11. Data Collection

# Goals of the Institutional Referral Procedure

- For clients new to DHS only, screen for referrals where insufficient placement efforts were made:
  - HCF will attempt more placements or document their efforts in more details
- Screen for referrals of persons from health care facilities (HCF) who may be medically inappropriate for shelter and cannot obtain the level of care needed in shelter:
  - Avoid shelter entry
  - Place in appropriate level of care
- Coordinate discharge and care for persons discharged to shelter who are medically appropriate for shelter but have significant medical needs
  - Communication
  - Coordination
  - Improve health outcomes
  - Reduce high utilization

# Overview of Shelter System

- **There are no respite and no medical shelters in the DHS shelter system**

- DHS programs within the scope of the Referral Form:
  - Single Adult Shelters
  - DHS Street Solutions sites
- Home care cannot be provided on an ongoing basis
- All single adult clients have to be able to perform their ADLs
- Pregnant women should be referred to family intake

# Single Adult Shelter System

- Congregate settings with shared bathrooms
- 3 intake facilities:
  - Men: 30th St.
  - Women: Franklin St. and Help Women's Center (HWC)
- 6 single adult assessment shelters
  - 4 for men
  - 2 for women
- Has various shelters including:
  - Employment
  - General
  - Mental health (MH)
  - Substance use (SUD)
  - And a small number of semi-specialized (veterans, young adult, LBGTQI, older adults)
- MH and SUD shelters are served by MH and SUD providers
- Shelters do not provide nursing services or 24 hrs medical services
  - Home care is not possible except a limited number of services offered by Visiting Nurse Services on a case-by-case basis

# DHS Street Solutions

- **Drop-in Centers**
  - Showers, food, services
  - 6 operational in all five boroughs
- **Outreach**
  - 24/7 proactive canvassing, outreach, and engagement across the five boroughs, including streets and subways
- **Safe Havens**
  - 16 Safe Haven shelters
  - Solely take referrals from experienced street outreach teams
  - Low-barrier programs and flexible requirements, no curfew and private or semi-private rooms with shared bathrooms
  - Safe Haven staff are trained to manage the variety of behaviors and situations of chronically street homeless clients and most have on-site medical care
  - Most have on-site care at varying levels but they are not skilled nursing facilities, no DHS facilities provide skilled nursing or overnight medical services
- Please note that patients should never be discharged to the street

# The Referral Procedure

- Provides:
  - A clear understanding of how to refer a patient from a healthcare facility (HCF) to the DHS shelter system
  - Overview of the shelter system
  - Criteria for medical appropriateness and inappropriateness
  - Information on alternatives to shelter for patients who are homeless or unstably housed
  - Roles and responsibilities for DHS sites, the DHS Office of the Medial Director (OMD), and HCF
  - Found at: https://www1.nyc.gov/site/dhs/shelter/singleadults/single-adults-hospital.page

# 2018 New Form Guidelines

- Single form sent at a single point in time
- Must be emailed to the appropriate DHS facility/office
  - Please note that typing the form is best practice however if this is not possible handwritten forms will be accepted
  - After July 1, faxes will not longer be accepted and all forms must be emailed to the appropriate site
- Determinations will be made with in 1 business day for inpatient stays less than 30 days, and within 2 business days for inpatient stays 30 days or more
- Specific criteria for medical appropriateness must be met
- Form, procedure, and training presentation found at: https://www1.nyc.gov/site/dhs/shelter/singleadults/single-adults-hospital.page
- Rigorous data collection methods

# Discharge Guidelines for Single Adult Shelters

- HCF will receive a response from DHS within:
  - 1 business day for stays less than 30 days
  - 2 business days for stays 30 days or more
- Once a positive determination is received, HCF can discharge the client, but **only between** the hours of 9:00am and 3:00pm Mon-Fri
- Only patients who are able to live entirely independently (perform ADLs) are appropriate
  - Patients may have limitations or special needs, including:
    - Medical assistance up to twice per day by a visiting nurse
    - Wounds that are not overly weeping and draining
    - Needed access to a temporary bed for rest
    - Use of ambulatory aids, enhanced equipment, or a first floor placement
    - Medically necessary diet
    - Use of an oxygen concentrator

# Discharge Guidelines for Single Adult Shelters

- HCF should start the discharge process early in the hospital stay. For information on asking patients about their housing stability see slide 35
- HCF should never discharge a patient without first submitting a Referral Form and receiving a positive determination
- For referral of clients new to DHS (or not at DHS >1 year), HCF are expected to assist clients in staying in current housing or finding alternatives to DHS shelter prior to submitting a referral form
- All follow-up information must be included in the referral form or be submitted to the receiving shelter on day of discharge at the latest
- HCF should submit clinical support documentation for reasonable accommodations with the Referral form for all appropriate cases

# Absolute Exclusion Criteria

**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.

*New!

# Relative Exclusion Criteria

| **Relative Exclusion Criteria for DHS single adult shelter or Safe Haven**<br>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<br>• Colostomy bag<br>• Tracheostomy/ feeding tube | • Intra-muscular or intra-venous medication administration via nurse- no more than two per day, must be prearranged by HCF and limited to no more than 2 weeks |

If a patient meets these criteria, the DHS facility or DHS Medical Office will speak with the healthcare facility to confirm that the patient can manage all ADLs including the condition listed in this section, and is stable and independent.

# Reasonable Accommodation Form

- https://www1.nyc.gov/assets/dhs/downloads/pdf/client-accom-request-form.pdf
- Asks for the patient information and reasonable accommodation need (can be filled out at the hospital)
- Include supporting documentation
- The form and supporting documentation should be printed and given to the patient to give to the shelter director upon arrival.

# The Referral Process

1. After determining that a patient is homeless, the HCF should call the DHS Referral Line at 212-361-5590 to determine if a patient is a current DHS client. The HCF will receive:
   - For returning clients, the name, phone number, and email of the shelter director of the patient's assigned shelter
   - For new clients, the email of OMD or women's intake*:
     - DHS-HCFreferral@dhs.nyc.gov for men,
     - HCF-Referral@helpusa.org for women.
2. The HCF will complete**:
   - All sections for patients who are **new** to the DHS single adult shelter system or have been **out of shelter for 12 months or more**
   - All sections **except** Section 2 for patients returning to shelter/ safe haven

*The HCF is responsible for obtaining consent to share clinical information with DHS prior to submitting the referral form
**The form must be filled out as a fillable PDF, handwritten forms will not be accepted

# The Referral Process

3. HCF will email the completed form to the appropriate contact (shelter, safe haven, outreach team, women's intake, or medical office)
   - For all potentially eligible clients, it is best practice that an HRA 2010e supportive housing application be completed
   - HCF **should not** submit referrals for clients who meet the absolute exclusion criteria

4. Upon receipt of the referral, the form will be reviewed to determine if additional information is needed or the client is medically appropriate

5. The reviewer will respond via email with a determination regarding medical appropriateness within 1 business day for stays of less than 30 days, and 2 business days for stays of 30 days or more
   - Please note that if the DHS reviewer requests additional information the 1-2 day 'clock' pauses until requested information is received from the HCF

6. Upon receipt of a positive determination, the HCF may discharge the patient anytime between 9:00am and 3:00pm, Mon-Fri, after coordinating with the receiving shelter for persons who still have serious medical needs

# The Referral Process - Discharge Coordination

- The HCF will be asked to:
  - Make clear on the referral form if the client has complex medical needs
  - Provide clinical support documentation for a reasonable accommodation if necessary
- For patients with persistent medical needs and those who require a bed the same day, the HCF will contact the destination DHS facility prior to discharge to discuss the need for a bed at time of discharge
- The shelter/safe haven and HCF are jointly responsible for coordinating the discharge of the client
- The HCF must:
  - Arrange all appropriate follow-up care including transportation (or establish that the client can independently travel to all appointments)
  - Provide a minimum of 2 week medication supply to the patient upon discharge unless otherwise directed
  - Provide oxygen concentrator if medically appropriate for patients requiring oxygen therapy
  - Communicate all follow-up information with the destination shelter staff

# The Referral Process - Inappropriate Referrals

- If a patient arrives and the referral is inappropriate or incomplete due to:
  - Inappropriateness due to medical reasons,
  - No referral form was sent, or
  - Lack of discharge planning;

  The DHS site will submit a notification to their medical provider if they have one, or otherwise DHS OMD, via their Program Administrators
- The medical provider or OMD will follow up or file a complaint with the HCF, relevant HCF association, and the appropriate state agency
- Quarterly reports on inappropriate referrals will be produced

# The Referral Process- Roles and Responsibilities

- OMD
  - Oversee and provide support and training for the referral procedure
  - Review referrals for men new to the DHS single adult shelter system
  - Collect and analyze referral data
- DHS site staff
  - Review incoming referrals from women new to the DHS single adult shelter system and all returnees
  - Communicate with the HCF regarding the determination and discharge coordination
  - Alert Program Administrator and their medical provider and as needed OMD, about inappropriate referrals
  - Collect and report data
- HCF staff
  - Assist patient in avoiding homelessness prior to sending referral form
  - Complete and send referral form *prior to* patient discharge
  - Follow this guidance and discharge on Mo-Fri 9am-3pm
  - Coordinate all necessary follow-up care for patient, provide 2 weeks of medications and communicate arrangements to shelter staff

# QUESTIONS???



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# The Referral Form

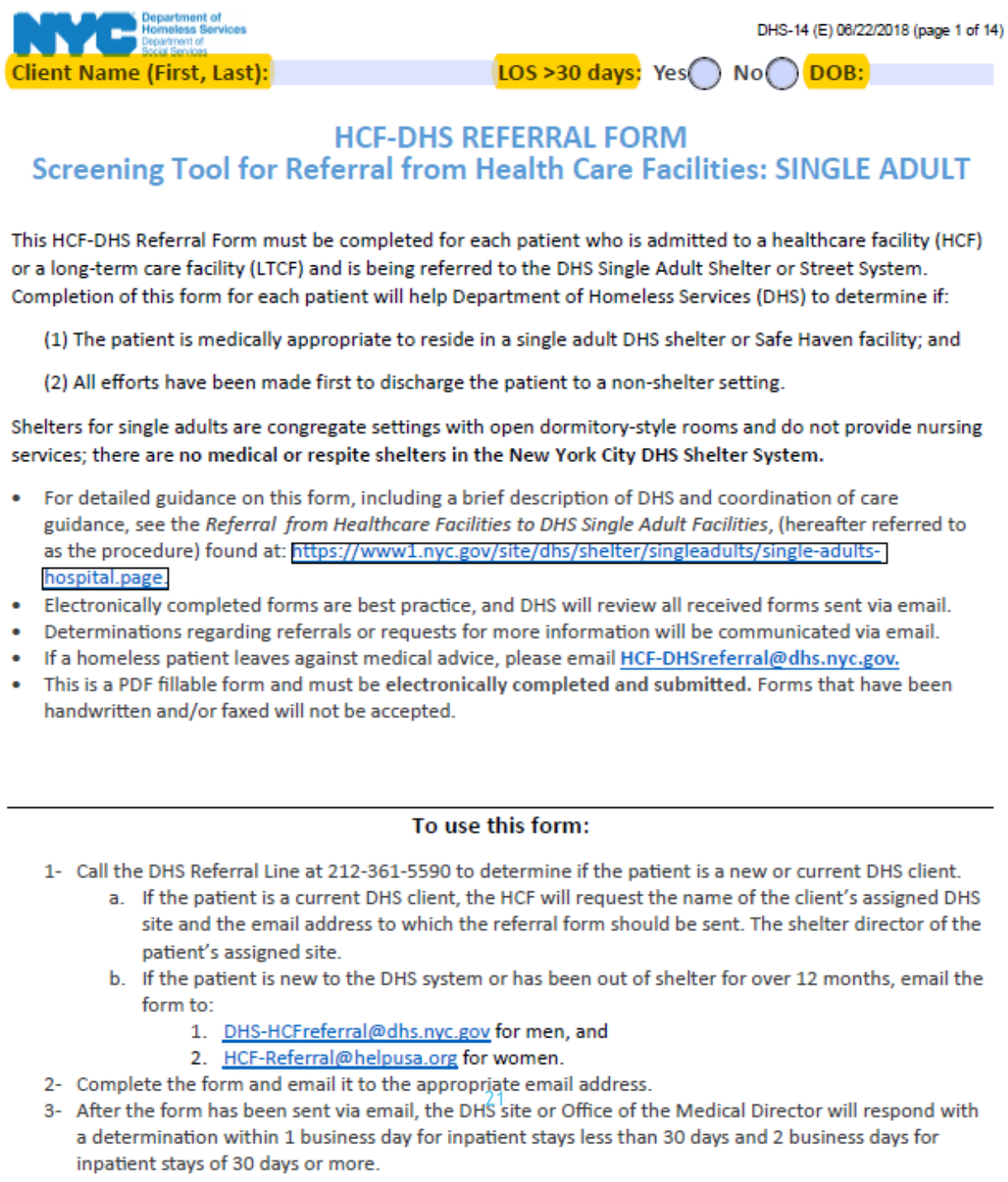
- Introduction and directions
- Section 1: Patient Demographic and Hospital Information
- Section 2: Past and Current Housing History
- Section 3: Clinical Information
- Section 4: Functional Status: Activities of Daily Living
- Section 5: Discharge Plan
- Section 6: Treating Team Signature

Shaded sections (in yellow) are required to be filled out by the HCF

# The Referral Form

Introduction and directions

- Includes directions on completing the form, where to send, and timeline
- Has information on medical appropriateness criteria, relative exclusion criteria
- Information for DHS use only in determining appropriateness of referral and other data collection variables
- All required sections will be shaded in YELLOW



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DHS-14 (E) 06/22/2018 (page 1 of 14)

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.

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**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. HCF-Referral@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.

# The Referral Form

Absolute and relative exclusion criteria

- Includes information on medical appropriateness criteria and relative exclusion criteria
- If a patient meets any of the conditions listed in the absolute exclusion criteria then a referral should not be sent
- If a patient meets any of the conditions listed in the relative exclusion criteria a referral may be sent but follow-up information may be requested



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**

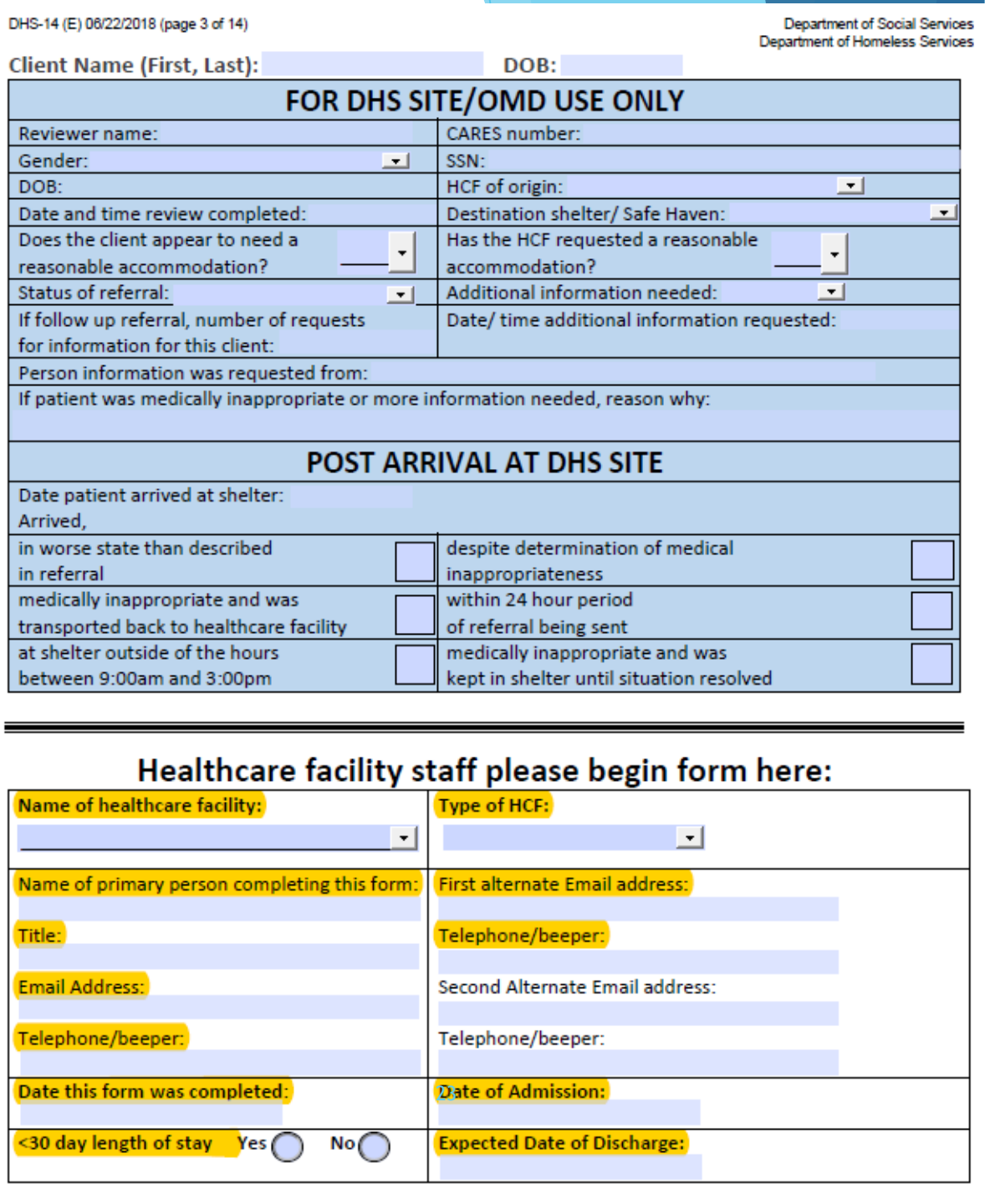
If one or more of the following apply to the patient, the HCF/LTCF may be contacted for additional information by the DHS Office of the Medical Director or relevant site.

- Requires infusion pumps/ PICC lines
- Colostomy bag
- Tracheostomy/ feeding tube
- 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

# The Referral Form

DHS determination and HCF contact information

- DHS determination section
  - Should only be completed by DHS site staff or OMD staff
  - Must be filled out upon receipt of the referral and receipt of the client
- HCF section (bottom half of the form) should be filled out by HCF
- Required for all referral submissions



DHS-14 (E) 06/22/2018 (page 3 of 14)

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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 ☐ |

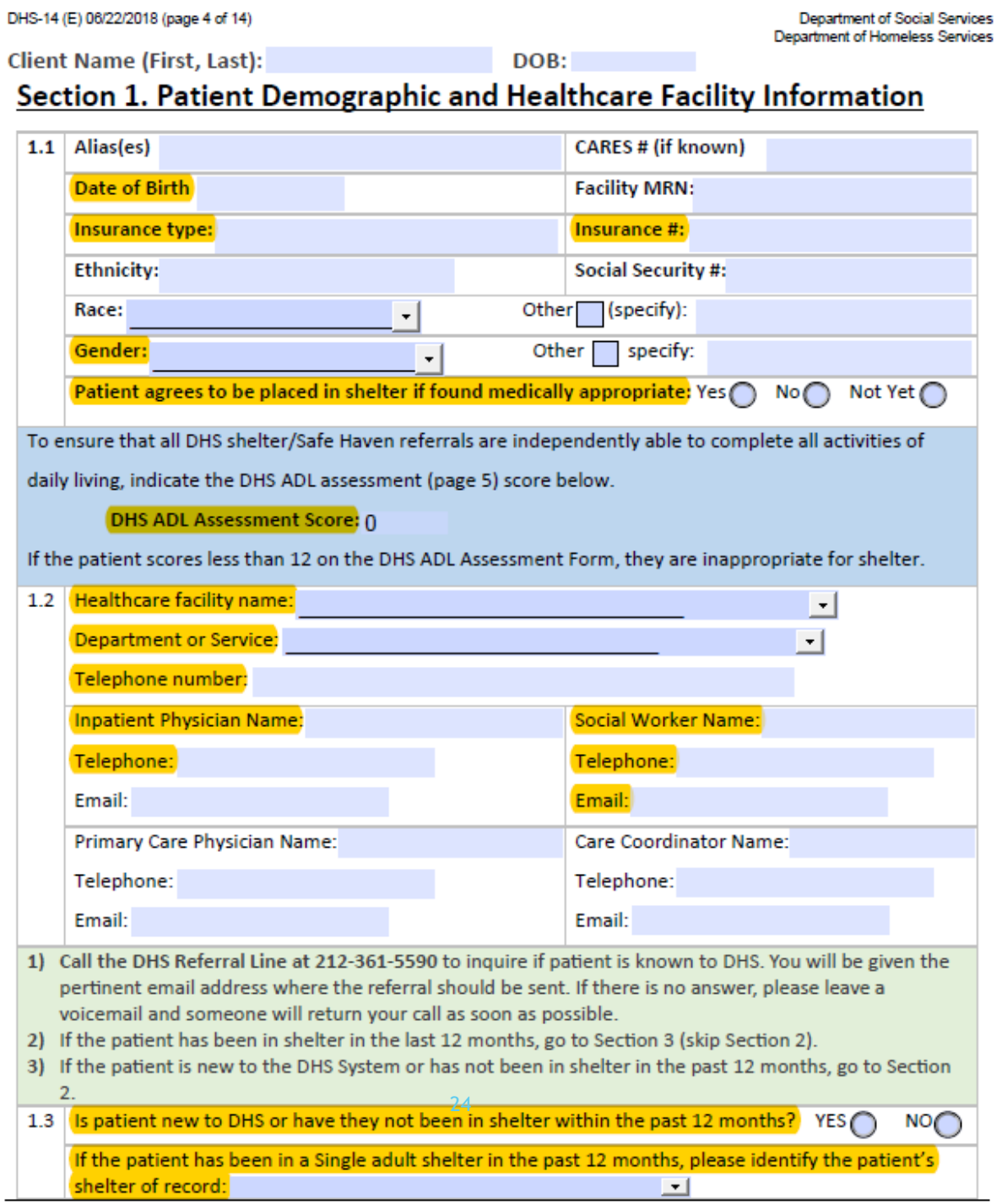
**Healthcare facility staff please begin form here:**

| | |
|---|---|
| Name of healthcare facility: | Type of HCF: |
| Name of primary person completing this form: | 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: |
| <30 day length of stay Yes ◯ No ◯ | Expected Date of Discharge: |

# The Referral Form

Section 1: Patient Demographic and Hospital Information

- Basic patient demographic information
- Contact information for the HCF treatment team staff
- Instructions on referring the patient to the correct DHS facility or OMD
- Required for all referral submissions



DHS-14 (E) 06/22/2018 (page 4 of 14)

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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: | Social Worker Name: |
| | Telephone: | Telephone: |
| | Email: | Email: |
| | Primary Care Physician Name: | Care Coordinator Name: |
| | Telephone: | Telephone: |
| | Email: | Email: |

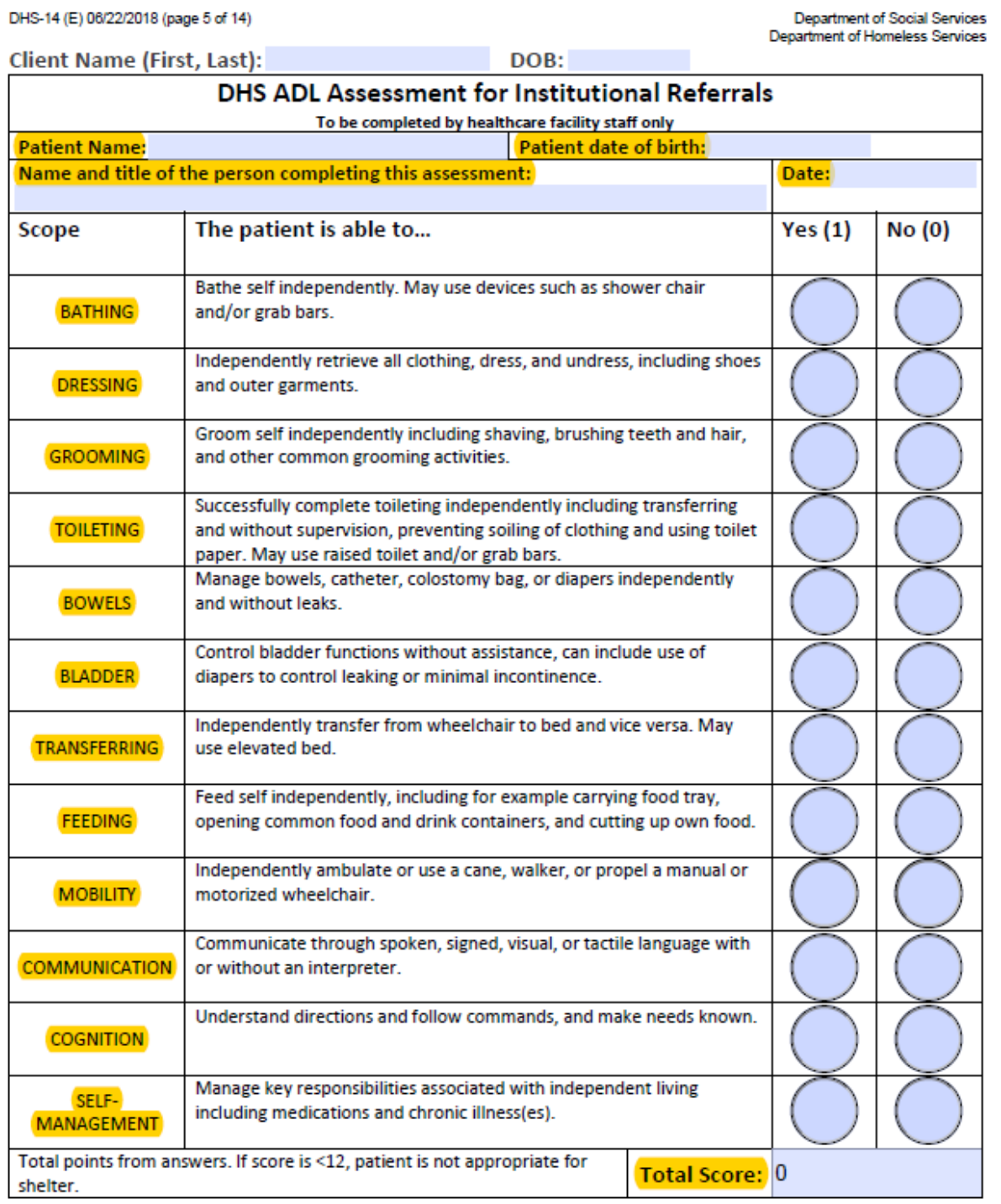
1) Call the DHS Referral Line at 212-361-5590 to inquire if patient is known to DHS. You will be given the pertinent email address where the referral should be sent. If there is no answer, please leave a voicemail and someone will return your call as soon as possible.
2) If the patient has been in shelter 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: | |

# The Referral Form

The DHS ADL Assessment form

- Patients must score a 12 to be considered appropriate for shelter
- If a patient scores less than a 12 they are not appropriate for shelter and the HCF staff should not continue to fill out the referral form.
- Required for all referral submissions



DHS-14 (E) 06/22/2018 (page 5 of 14)

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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:

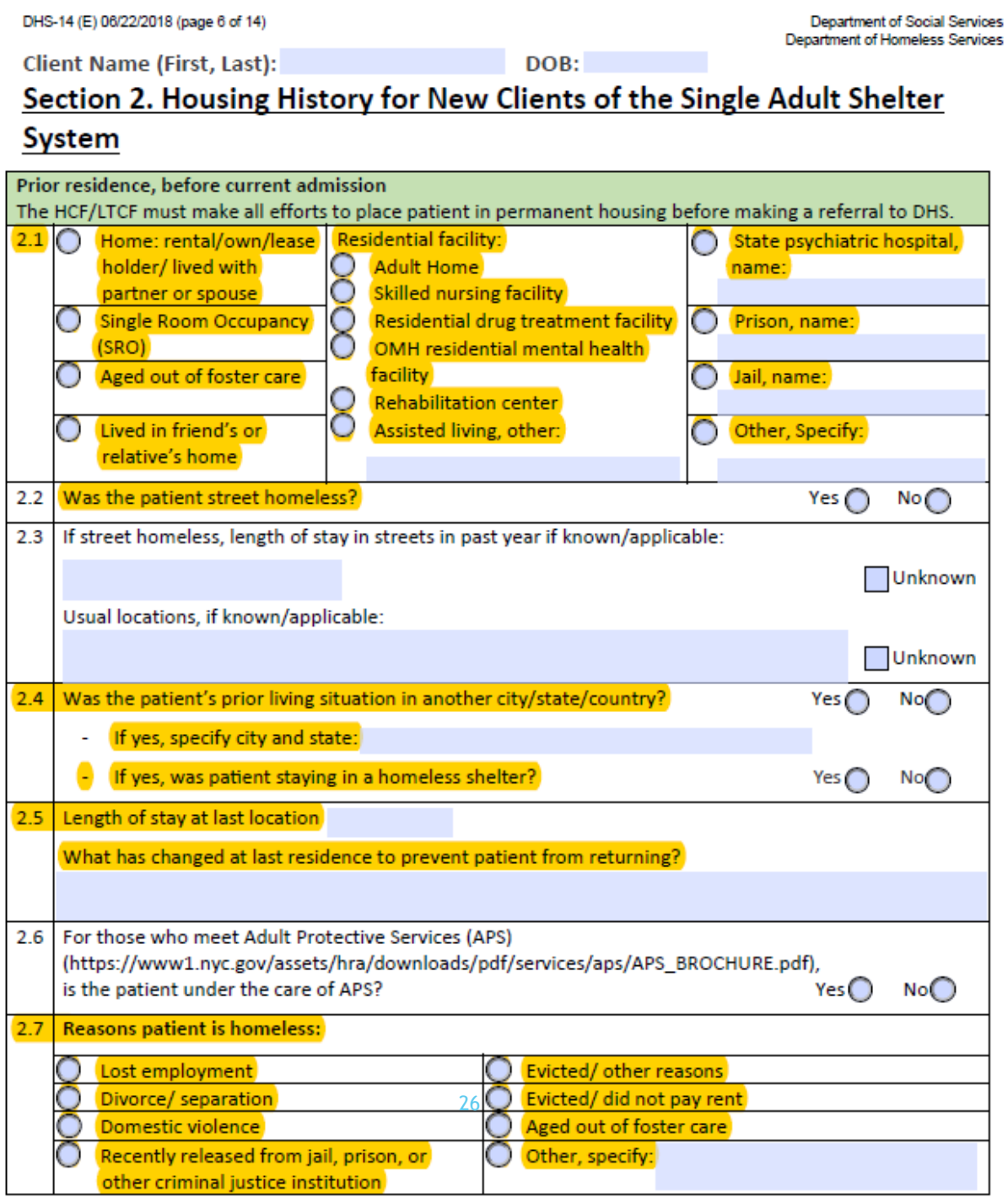
Name and title of the person completing this assessment: Date:

| 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 |

# The Referral Form

Section 2: Past and Current Housing History

- Prior housing history
  - Only one radio button should be selected
- Reasons for current homelessness
  - Only one radio button should be selected
- Efforts to place patient in alternative housing
  - Please list all attempts
- Required only for NEW clients



DHS-14 (E) 06/22/2018 (page 6 of 14)

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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
- Single Room Occupancy (SRO)
- Aged out of foster care
- Lived in friend's or relative's home
- Residential facility:
  - Adult Home
  - Skilled nursing facility
  - Residential drug treatment facility
  - OMH residential mental health facility
  - Rehabilitation center
  - Assisted living, other:
- State psychiatric hospital, name:
- Prison, name:
- Jail, name:
- 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?

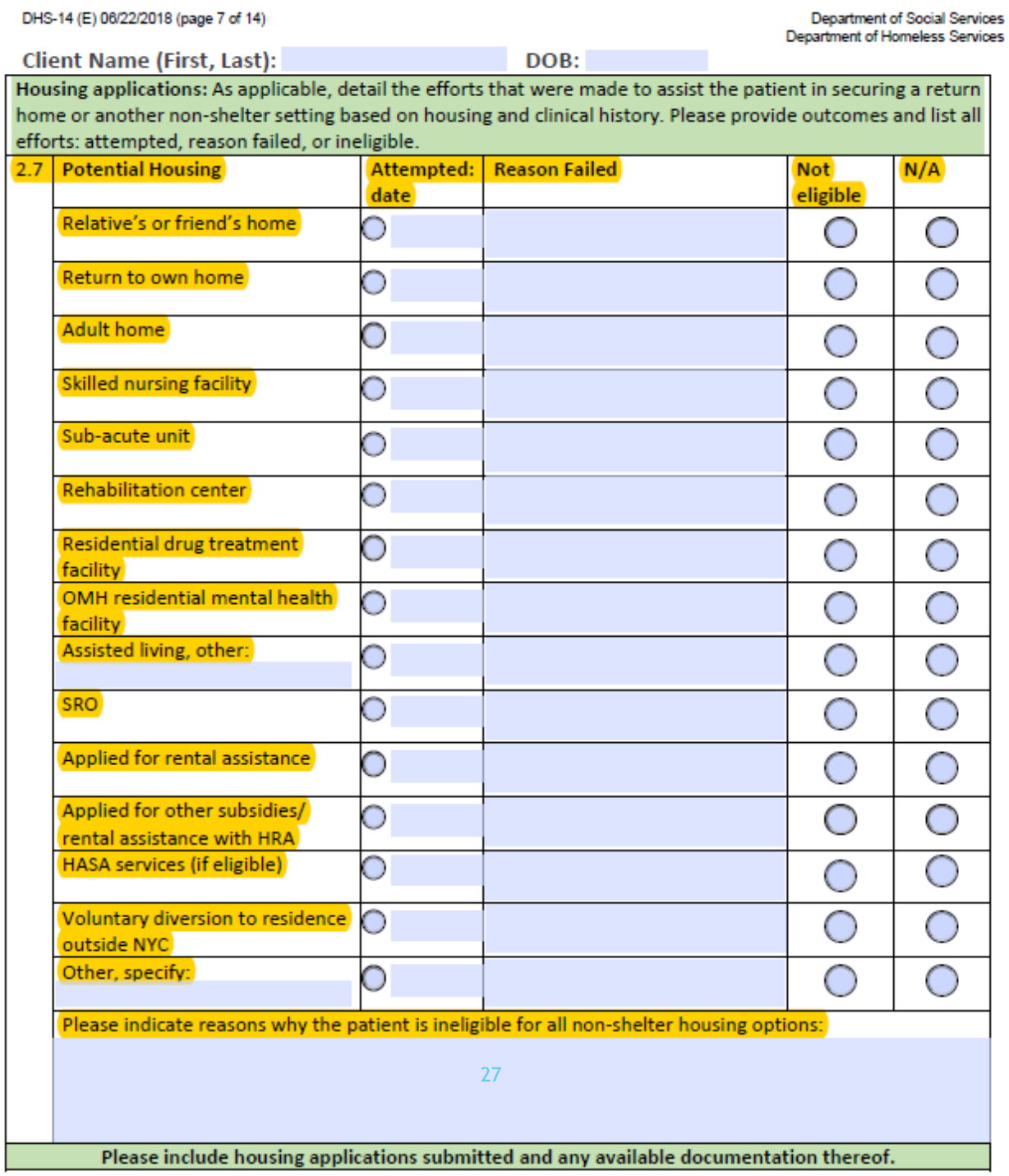
2.6 For those who meet Adult Protective Services (APS) (https://www1.nyc.gov/assets/hra/downloads/pdf/services/aps/APS_BROCHURE.pdf), is the patient under the care of APS? Yes No

2.7 **Reasons patient is homeless:**
- Lost employment
- Divorce/ separation
- Domestic violence
- Recently released from jail, prison, or other criminal justice institution
- Evicted/ other reasons
- Evicted/ did not pay rent
- Aged out of foster care
- Other, specify:

# The Referral Form

Section 2: Past and Current Housing History

- Prior housing history
  - Only one radio button should be selected
- Reasons for current homelessness
  - Only one radio button should be selected
- Efforts to place patient in alternative housing
  - Please list all attempts
- Required only for NEW clients



DHS-14 (E) 08/22/2018 (page 7 of 14)

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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:

27

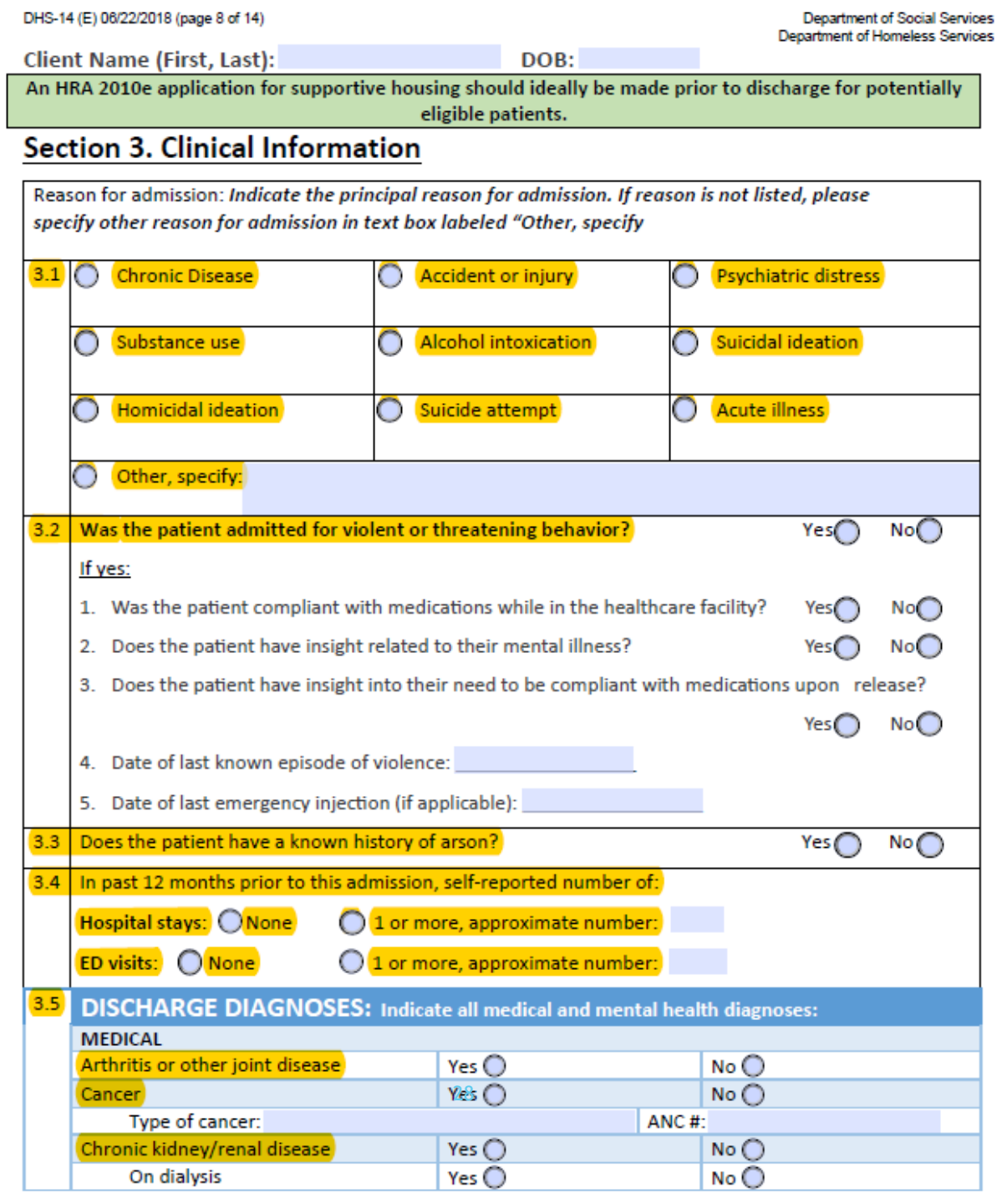
**Please include housing applications submitted and any available documentation thereof.**

# The Referral Form

Section 3: Clinical Information

- Reason for current admission
  - Only one radio button should be selected
- Information on client if admitted due to violent or threatening behaviors
  - If patient was admitted due to violent or threatening behaviors, follow up questions 1-5 are required
- Arson and hospitalization history
- Diagnoses upon discharge information
- Required for all referral submissions

Department of Homeless Services
Department of Social Services



DHS-14 (E) 06/22/2018 (page 8 of 14)

Department of Social Services
Department of Homeless Services

Client Name (First, Last): DOB:

**An HRA 2010e application for supportive housing should ideally be made prior to discharge for potentially eligible patients.**

## 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 labeled "Other, specify*

| | | | |
|---|---|---|---|
| 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:

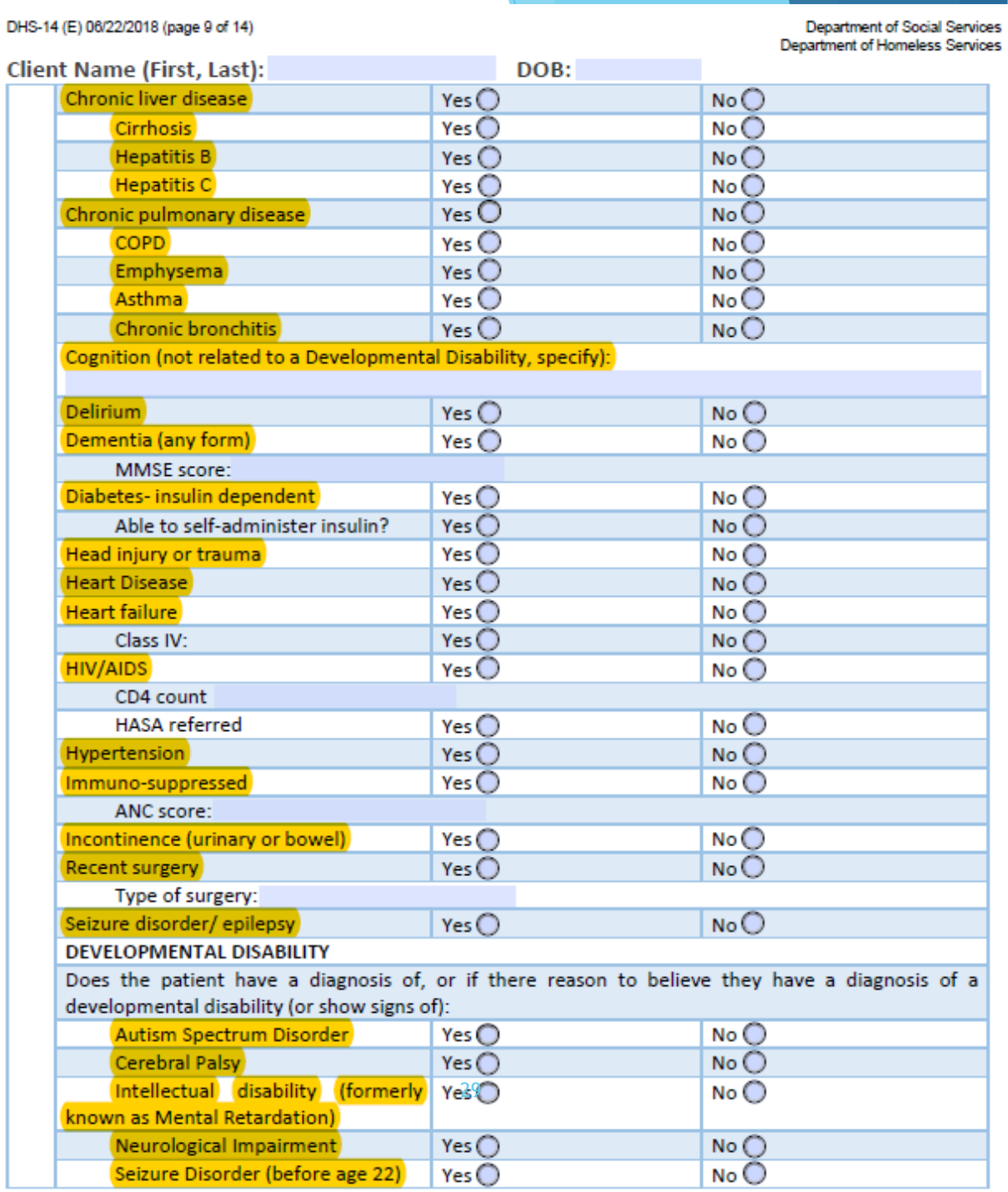
3.5 **DISCHARGE DIAGNOSES: Indicate all medical and mental health diagnoses:**

| 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 |

# The Referral Form

Section 3: Clinical Information

- Reason for current admission
  - Only one radio button should be selected
- Information on client if admitted due to violent or threatening behaviors
  - If patient was admitted due to violent or threatening behaviors, follow up questions 1-5 are required
- Arson and hospitalization history
- Diagnoses upon discharge information
- Required for all referral submissions



DHS-14 (E) 06/22/2018 (page 9 of 14)

Department of Social Services
Department of Homeless Services

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

| | | |
|---|---|---|
| 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 ◯ |
| **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 ◯ |

# The Referral Form

Section 3: Clinical Information

- Reason for current admission
  - Only one radio button should be selected
- Information on client if admitted due to violent or threatening behaviors
  - If patient was admitted due to violent or threatening behaviors, follow up questions 1-5 are required
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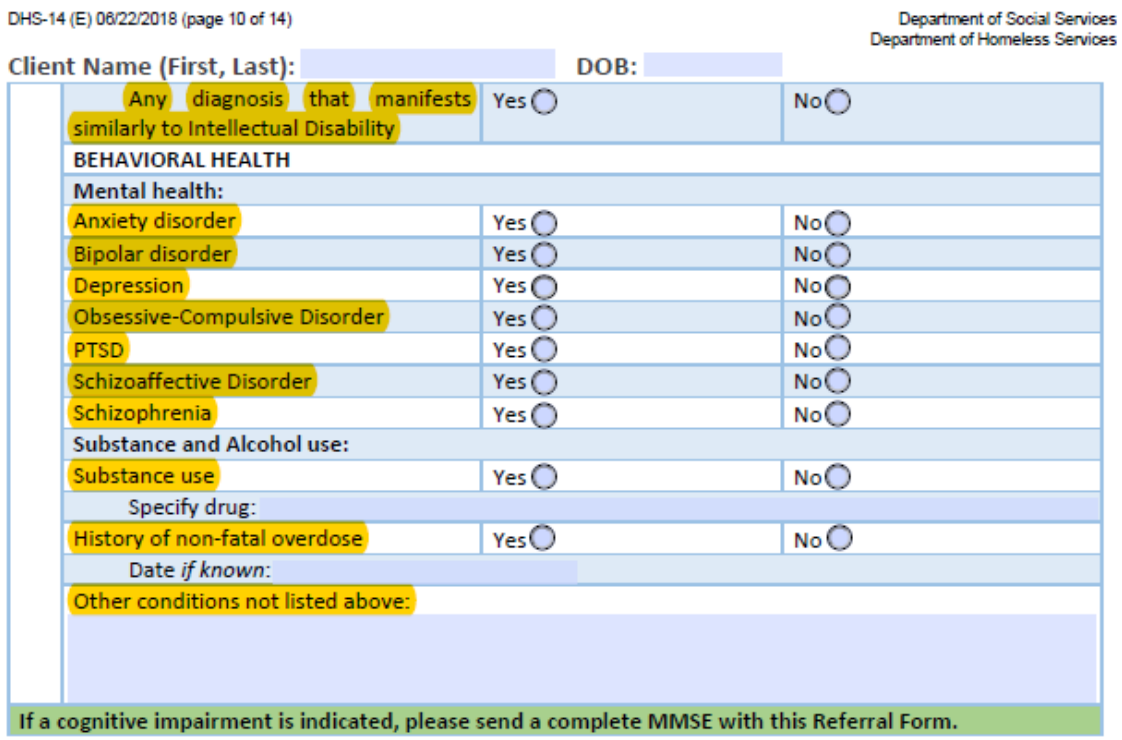
- Required for all referral submissions



DHS-14 (E) 06/22/2018 (page 10 of 14)

Department of Social Services
Department of Homeless Services

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

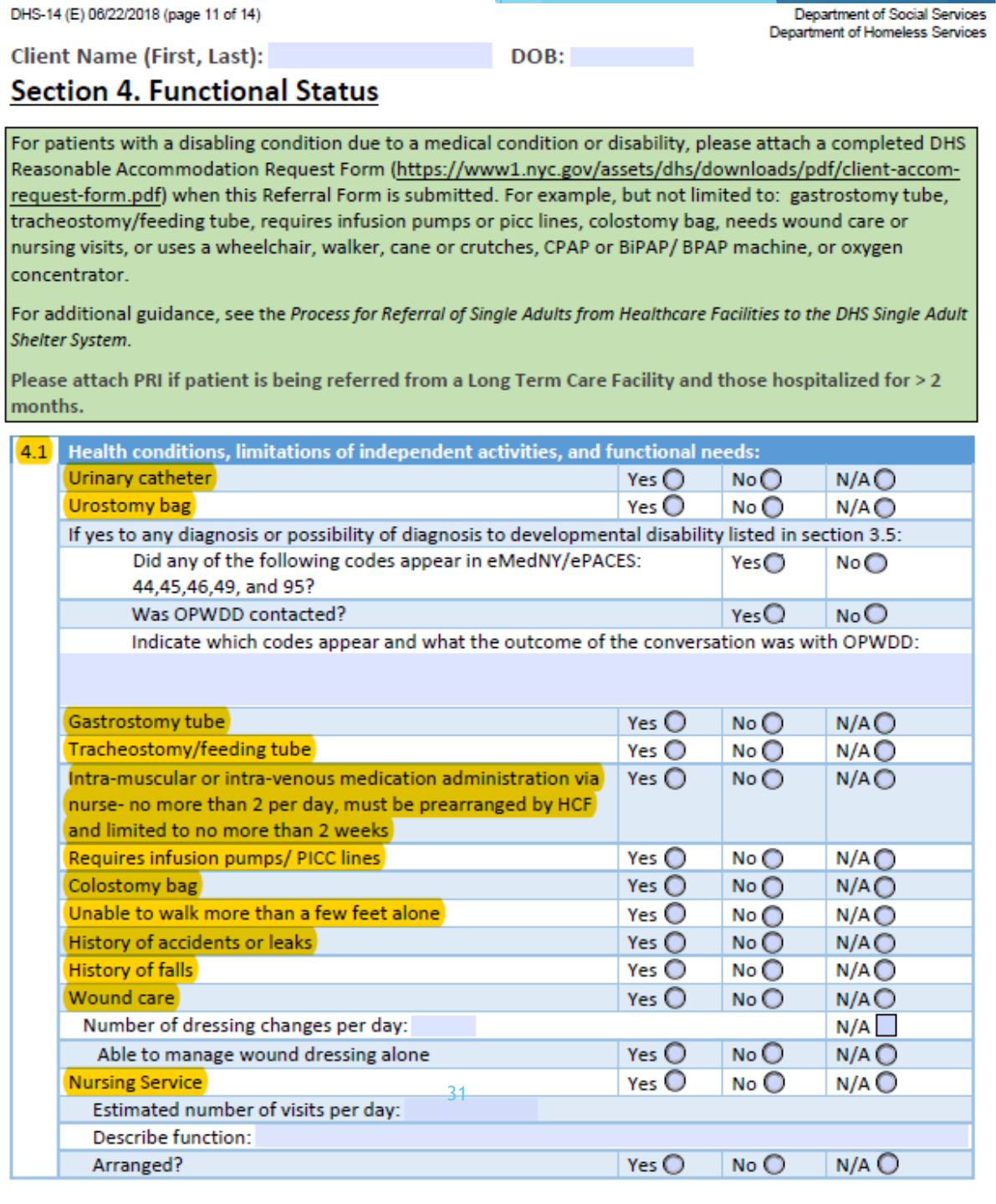
| | | |
|---|---|---|
| Any diagnosis that manifests similarly to Intellectual Disability | Yes ◯ | No ◯ |
| **BEHAVIORAL HEALTH** | | |
| **Mental health:** | | |
| Anxiety disorder | Yes ◯ | No ◯ |
| Bipolar disorder | Yes ◯ | No ◯ |
| Depression | Yes ◯ | No ◯ |
| Obsessive-Compulsive Disorder | Yes ◯ | 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 *if known*: | | |
| Other conditions not listed above: | | |

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

# The Referral Form

Section 4: Functional Status: Activities of Daily Living

- Information on relative exclusion criteria
- Any reasonable accommodation needs
- Link to the Reasonable Accommodation form online
- Durable medical equipment needs
- Medication list- can be attached or copy/pasted into the textbox provided
- Required for all referral submissions



DHS-14 (E) 06/22/2018 (page 11 of 14)

Department of Social Services
Department of Homeless Services

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*.

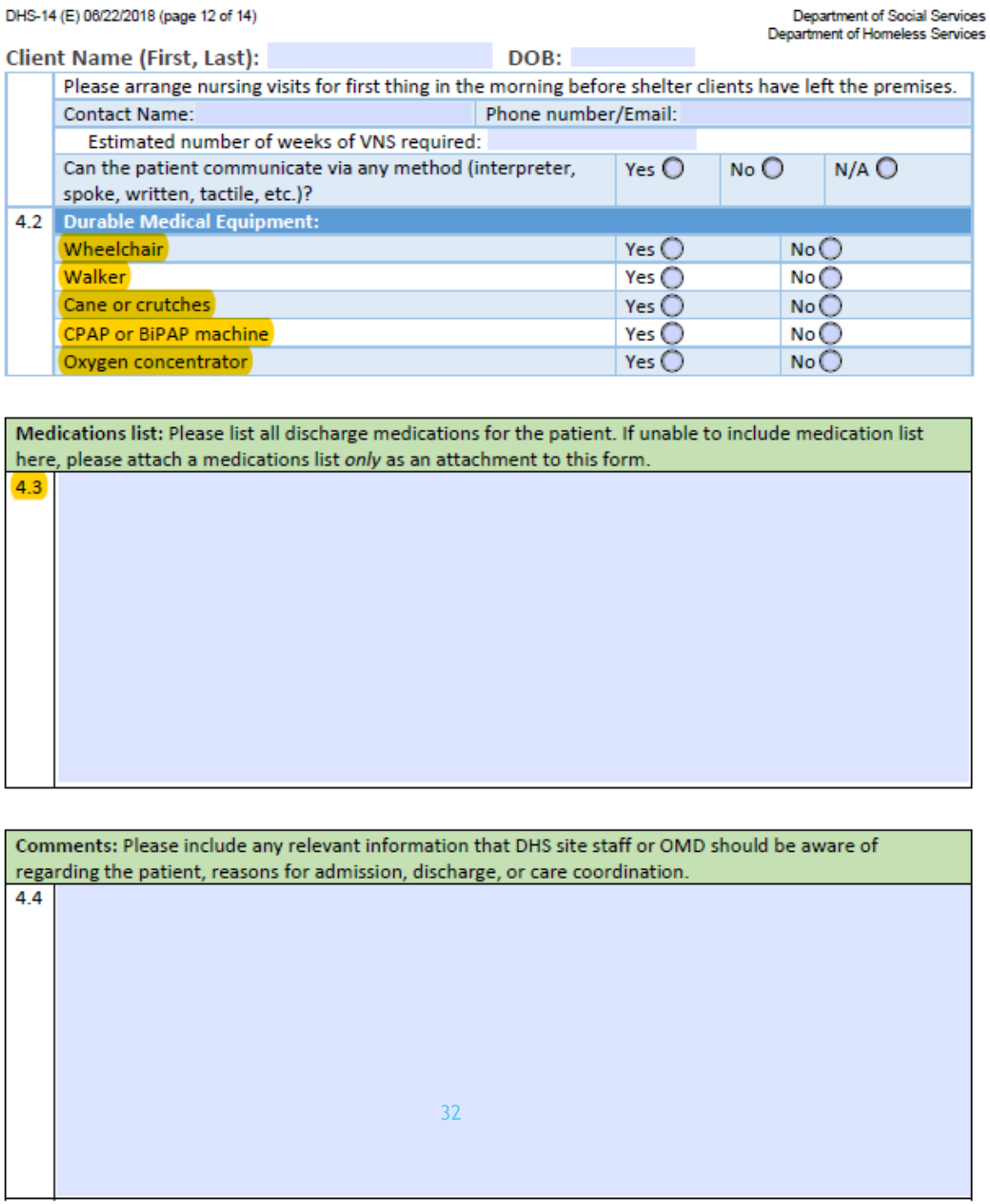
**Please attach PRI if patient is being referred from a Long Term Care Facility and those hospitalized for > 2 months.**

| 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 ○ |

# The Referral Form

Section 4: Functional Status: Activities of Daily Living

- Information on relative exclusion criteria
- Any reasonable accommodation needs
- Link to the Reasonable Accommodation form online
- Durable medical equipment needs
- Medication list- can be attached or copy/pasted into the textbox provided
- Required for all referral submissions



DHS-14 (E) 06/22/2018 (page 12 of 14)

Department of Social Services
Department of Homeless Services

**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.

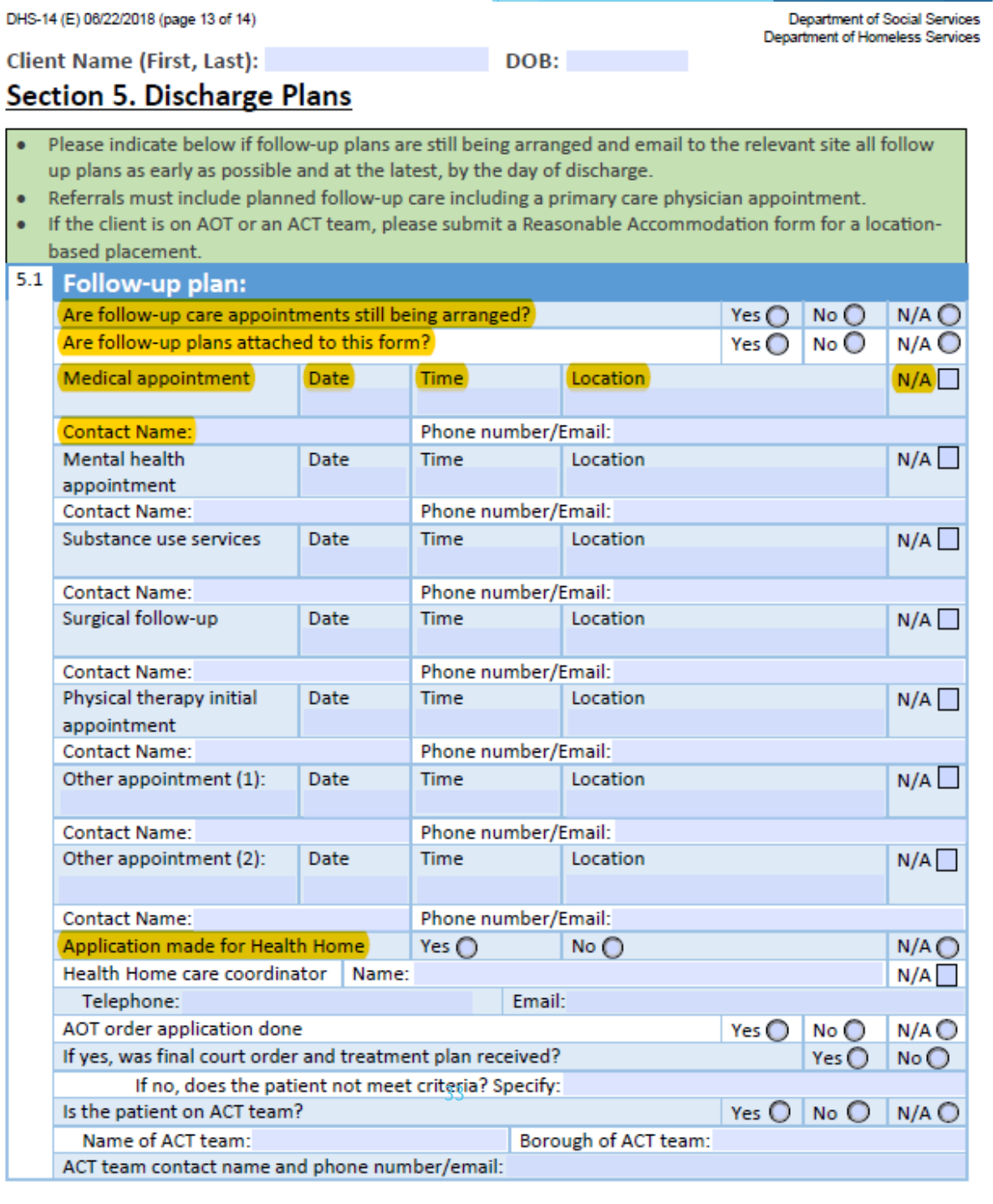
4.4

32

# The Referral Form

Section 5: Discharge Plan

- All follow-up appointments that have been made at time of referral submission
- If the HCF is still making follow-up plans, submit plans by day of discharge
- All discharged patients must have at least a follow-up appointment with a PCP
- Please note that referrals to a walk in clinic are not acceptable follow-up plans
- Required for all referral submissions



DHS-14 (E) 06/22/2018 (page 13 of 14)

Department of Social Services
Department of Homeless Services

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.

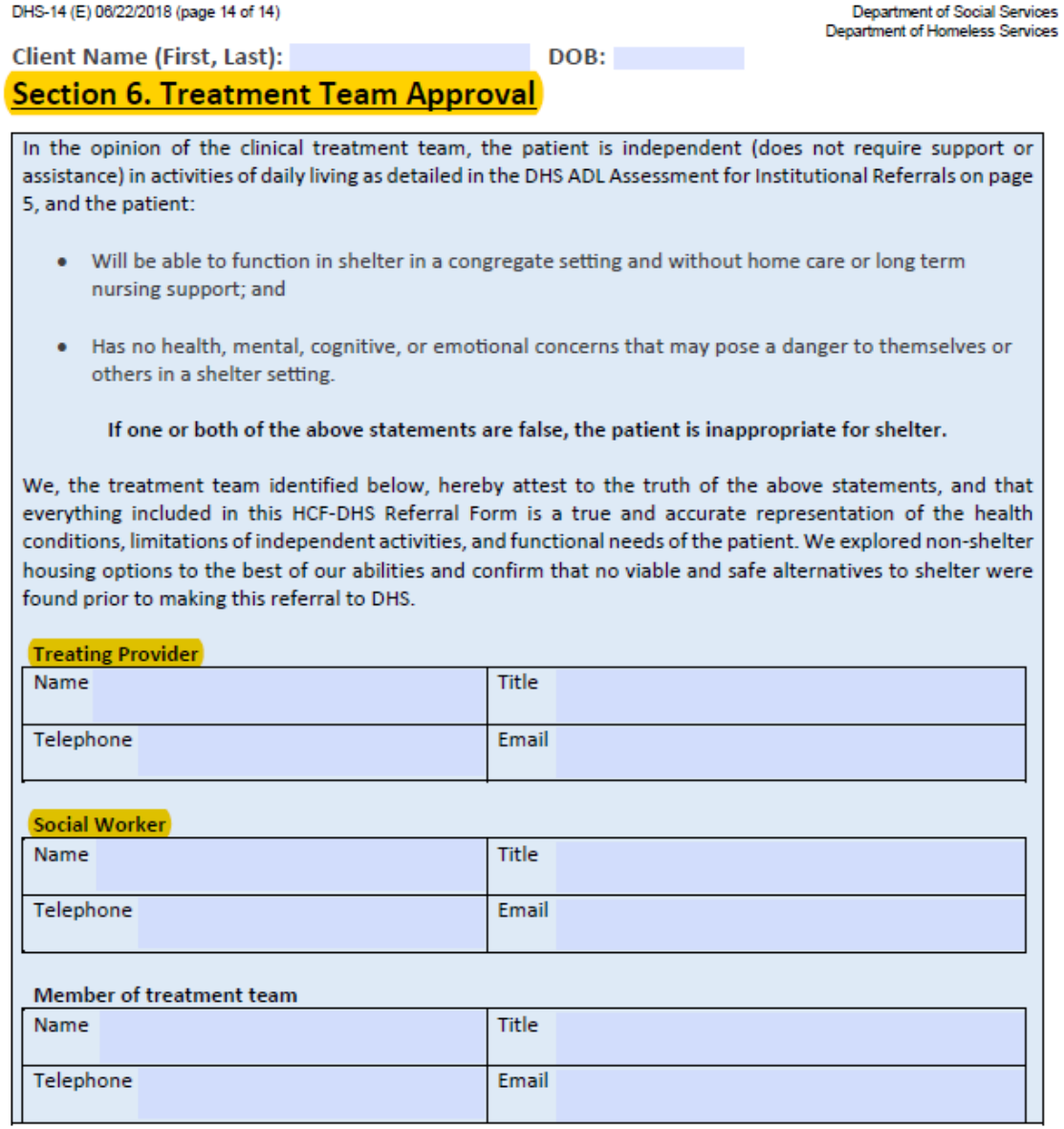
**5.1 Follow-up plan:**

| | | | | |
|---|---|---|---|---|
| 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: | | | | |

# The Referral Form

Section 6: Treatment Team Approval

- Must be approved by at least one member of the treatment team
- Required for all referral submissions



DHS-14 (E) 06/22/2018 (page 14 of 14)

Department of Social Services
Department of Homeless Services

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, cognitive, or emotional concerns that may pose 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 |

# QUESTIONS???

Department of Homeless Services
Department of Social Services

# Identifying and Assisting Homeless Patients

- To facilitate a faster referral and ensure that DHS has time to review all incoming referrals, it is necessary to identify if a patient is homeless early in the hospital stay.

- The following questions may be asked to ascertain if a patient is or may become homeless during their inpatient stay:

  1- Where did you stay last night?

  2- Can you return to this place upon discharge?

  3- If not, is there other housing where you can stay upon discharge?

- State that they will not be treated differently at the hospital if they are homeless or unstably housed.
- Identifying social determinants of health is critical to improving health outcomes and reducing inappropriately high utilization of medical services
  - See Billioux A, Standardized Screening for Health-Related Social Needs in Clinical Settings. National Academy of Medicine, 2017.

# Identifying and Assisting Homeless Patients

- If the patient cannot return to housing, the HCF should assist them in any referrals to HRA or other housing support resources
- If the patient is being discharged after a long inpatient stay the HCF should provide evidence of applications to permanent housing or support programs
- If a patient needs assistance with ADLs or skilled nursing care, they need to be referred elsewhere
- If the patient stayed on the street or in a shelter, please call the DHS Referral Line at 212-361-5590
- If the patient stayed at a friend's house, at a relative's house, etc., and state they cannot return there upon discharge, please call HRA at: 718-557-1399
- If a patient has development disabilities, contact OPWDD at: 646-766-3276

# Assisting Patients At-Risk of Homelessness

- If the patient has a place to return but this housing is at risk:
  - To refer to Homebase for eviction prevention, mediation with landlord or primary tenants, or temporary assistance, call 311 for the nearest Homebase office or go to https://www1.nyc.gov/site/hra/help/homebase.page. Please call to make an appointment.
  - If the patient has rent arrears, HRA provides grants at local Job Centers in order to cover arrears and prevent eviction https://www1.nyc.gov/site/hra/help/cash-assistance.page
  - For ongoing rental assistance, SEPS is the ongoing rental assistance program available in the community for single adults who meet the eligibility criteria (see next slide).

# Assisting Patients At-Risk of Homelessness

- SEPS is available for single adults living in the community who meet the following criteria:
  - Income below 200% of the federal poverty line
  - A veteran at-risk of shelter entry OR
  - In eviction proceedings or evicted within the past year and one of the following criteria:
    - Active APS case
    - Shelter history
    - Rent controlled apartment

- Apply for SEPS at Riseboro for housing in Brooklyn, Queens and Staten Island and at Bronxworks in the Bronx and Manhattan

**Riseboro - Brownsville**

145 East 98th Street Brooklyn, NY 11212

Call 917-819-3200 for an appointment

**Riseboro - Bushwick**

1475 Myrtle Avenue Brooklyn, NY 11237

Call 347-295-3738 for an appointment

**Bronxworks**

630 Jackson Avenue, Bronx, NY 11455

Call 929-252-7110 for an appointment

# What is Supportive Housing?

- Permanent affordable housing with voluntary support services.
  - Congregate: One building, often combined with affordable housing for the community
  - Scattered-site: Private market apartments rented in the community in which clients are visited by case managers
- Clients have their own units and pay 30% of their income toward rent
- Access to on-site social services to promote community integration and support to achieve maximum independence

Jericho Project's Kingsbridge Veterans Residence CD 14

# Who is Served in Supportive Housing?

- Homeless individuals living with mental illness and/or struggling with substance use disorders
- Individuals with HIV/AIDS
- Youth aging out of foster care
- High-risk homeless families in which the head of household living with mental illness, substance use disorders, and/or HIV/AIDS
- Homeless veterans with a disabling condition
- High-cost Medicaid recipients who are homeless and living with a disabling condition

# Services Provided in Supportive Housing

- Person-centered planning to develop effective goals related to housing stability, financial security, and progress toward recovery.
- Evidence based approaches such as Motivational Interviewing, Health and Wellness Self-Management, and Trauma Informed case management.
- Utilization of peer services and tenant participation activities for inclusive and comprehensive program operations.
- On site services and community service linkage to support residents to achieve their recovery goals and foster independence.

# Mayoral Commitment: Creating 15,000 Supportive Housing Units in Next 15 Years

| Population | Housing Type | Estimated Projections | Total by Population |
|---|---|---|---|
| **Single Adults** With SMI/SUD | | | **10,673** |
| | Congregate | 5,155 | |
| | Scattered-Site | 5,518 | |
| **Adult Families** Head of Household with SMI/SUD | | | **1,004** |
| | Congregate | 341 | |
| | Scattered-Site | 663 | |
| **Families with Children** | | | **2,087** |
| Head of Household with SMI/SUD | Congregate | 654 | |
| | Scattered-Site | 982 | |
| Young Adults, Ages 18-25 w/ Children or Pregnant Women | Congregate | 361 | |
| | Scattered-Site | 90 | |
| **Young Adult Singles, Ages 18-25** | | | **1,236** |
| | Congregate | 989 | |
| | Scattered-Site | 247 | |
| **TOTAL** | | | **15,000** |

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Department of Social Services

# Applying for Supportive Housing

- HRA's Placement Assessment and Client Tracking (PACT) unit reviews housing applications submitted by acute and long-term psychiatric hospitals, shelters, outreach teams, correctional facilities, and community-based agencies.
- This initiates the approval and placement process for a continuum of supportive housing options.
- Annually, the PACT unit reviews about 25,000 applications and 63% are approved for NY/NY and/or SMI housing.
- Generally, an application for supportive housing requires the following:
  - Psychiatric evaluation, by an appropriately licensed professional
  - Psychosocial Assessment
  - Housing documentation (unsheltered stay)
- The psychiatric and psychosocial assessment must be completed *no more* than 6 months prior to submission of the application.
- Application criteria can be found in the "What's New" section of PACTWeb.

# The Supportive Housing Coordinated Assessment Survey

- Prior to initiating a supportive housing application, it is recommended that a coordinated assessment survey is completed.
- The Coordinated assessment survey:
  - Is accessible to all PACT users
  - Generates a list of supportive housing and rental subsidies the household is potentially eligible for
  - If the Survey returns a ‘match’ on a client: income and identifying documents (i.e. SS card, birth certificate) and prior supportive housing applications for the last five years are available

# Supportive Housing Referral/Placement

Placement Agencies assist in referral and placement process:

- For NY/NY III approved individuals or families, PACT system electronically notifies the referral source and the appropriate Placement Agency – HRA/DSS, HASA, ACS, SOMH
- HRA/DSS makes electronic referrals of eligible clients for six (6) of the NY/NY III categories of permanent supportive housing
- NYC 15/15 approvals- Referrals/Placement Agency HRA/DSS
- For SMI and NY/NY I/II, the approved individuals are referred/placed by the referral source or through SPOA (managed by CUCS)
- CUCS publishes a NYC Vacancy Update every two weeks with housing provider intake contacts
- CUCS provides housing consultation and referral assistance by phone

# Supportive Housing Resources

- Contact the HRA technical user support for training and access to the Supportive Housing Application at 929-221-4515.
- Contact CUCS housing referral assistance at 212-801-3333.
- Visit CUCS website for SPOA process, vacancy update and other resources: cucs.org
- For placement information, or to find out the status of an application, contact Fuad Rasulov, Program Manager at (212) 607-2409 or rasulovf@hra.nyc.gov.

Department of Homeless Services
Department of Social Services

# Communicating with DHS Site Staff

- Communication between DHS sites and HCF is crucial for the wellbeing of our patients/clients
- HCF and DHS staff who are located within a short distance of each other are encouraged to set up visits and have the staff tour each facility to better understand the workflows and pathways of the other facility
- HCF will be provided with name, phone number, and email of the DHS site reviewer (on-site director or intake coordinator) when calling the DHS Referral Line to facilitate communication
- HCF will be provided a list of shelter/sites directors name, telephone number and email address
- Phone numbers and emails of referring HCF staff and treating physician should be noted on the referral to facilitate care coordination and communication

# Sending and Receiving Emails

- HCF are required due to HIPAA regulations to send encrypted emails.
  - These emails may be sent ‘as normal’ or via a third party encryption site such as Kiteworks depending on the email server that is used by the referring healthcare facility
- DHS recipients of emails may need, depending on the type of encryption to register and log into an encryption site such as Kiteworks.
  - OMD suggests that DHS site staff set up the same username and password for all encryption sites that are used to access emails.
  - This username and password should be shared with all individuals who will be receiving encrypted emails.
  - If DHS staff have any questions or concerns about accessing encrypted emails through a third party, please contact the Office of the Medical Director at DHS-HCFReferral@dhs.nyc.gov

# The Referral Process- Workflow

A healthcare facility (HCF) determines they have a homeless patient with no alternative options

The HCF calls HCF referral line at 212-361-5590 to determine if the client has a current shelter of record

**Patient has not been in a DHS shelter ever or within in the past year but is willing to go**

**Patient was in shelter within past year and is willing to return**

**Patient was in a Safe Haven within the past year and is willing to return**

**The patient is street homeless and is unwilling to go to shelter**

HCF fills out Referral Form at https://www1.nyc.gov/site/dhs/shelter/singleadults/single-adults-hospital.page, and emails the form to the receiving shelter, Safe Haven, Outreach Team, Medical Director's Office, or women's intake as appropriate

HCF will receive a determination regarding the medical appropriateness of the patient within 2 business days

If the patient is not appropriate for discharge to a DHS shelter, the HCF may be offered resources if available to create a safe discharge plan for the patient to a more appropriate setting

If the patient is appropriate for shelter the HCF can plan to discharge the patient between the hours of 9:00am and 3:00pm Monday-Friday

If the patient can be accommodated, appropriate discharge plan is made and patient is discharged to the Safe Haven

If the patient cannot be accommodated, the HCF and Safe Haven will communicate

HCF contacts borough outreach team and works with the team to create an appropriate discharge plan

# Thank you!

- If you have any questions or comments on the new form, please reach out to Terre Pring at pringt@dhs.nyc.gov
- For discussion about clients being referred, contact Felicia Martin at fmartin@dhs.nyc.gov or Fabienne Laraque at flaraque@dhs.nyc.gov

The referral form and procedure will be rolled out on July 1, 2018.

Department of Homeless Services
Department of Social Services