Department of Homeless Services
Department of Social Services

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. 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.

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	

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:**

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:

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:	

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:**		

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 ◯ Residential drug treatment facility ◯ OMH residential mental health facility ◯ Rehabilitation center ◯ Assisted living, other:	◯ State psychiatric hospital, name:
	◯ Single Room Occupancy (SRO)		◯ Prison, name:
	◯ Aged out of foster care		◯ Jail, name:
	◯ Lived in friend's or relative's home		◯ 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? - If yes, specify city and state: - If yes, was patient staying in a homeless shelter?	Yes ◯ No ◯ 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:	

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 ◯

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		

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.

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 ◯

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	

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:				

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