Department of Homeless Services
Department of Social Services

OFFICE OF POLICY, PROCEDURES AND TRAINING

James K. Whelan
Executive Deputy Commissioner

DHS-PB-2019-017

SUBJECT:	APPLICABLE TO:	ISSUED:
Monthly Updates for DHS and DSS Forms	All DHS Staff, shelters and DHS facilities	July 26, 2019

■ PURPOSE

The purpose of this policy bulletin is to announce Department of Homeless Services (DHS) and Department of Social Services (DSS) forms that have been posted on eDocs as newly created or revised.

■ NEW FORMS

The following forms have been newly created and posted on eDocs:

- "Clinical Services Unit Permission to Administer Screenings to Adolescent Age
- 12-17" (**DHS-25**);
- "Clinical Services Unit Family Agreement" (**DHS-25a**);
- "Shelter Application Withdrawal Form" (**DHS-26**);
- "Appointment Notification" (**DHS-27**);
- "Referral to Intake Center" (**DHS-27a**);
- "ATTENTION ALL RESIDENCES" (**DHS-29**);
- "Notice of Temporary Suspension of Shelter Services" **(DHS-30**);
- "Notice Regarding Locker Inspection" (**DHS-31**);
- Notice Regarding Locker Inspection and Contraband" (**DHS-31a**);
- "Notice of No Smoking Regulations and Suspension for Infractions" (**DHS-32**);
- "NO SMOKING/OPEN FLAME POLICY" (**DHS-32a**);
- "Refusal of Shelter Bed Assignment" (**DHS-33**);
- "DRUG TESTING CONSENT FORM" (**DHS-34**);
- "RESIDENCY LETTER" (**DHS-35**);
- "Welcome to the Barbara Kleinman Shelter" (**DHS-36**);
- "CATHERINE STREET ADULT RESIDENCE" (**DHS-36a**);
- "CLIENT STORAGE POLICY" (**DHS-37**);
- "CONSTITUENT GRIEVANCE FORM" (**DHS-38**);
- "CONSTITUENT GRIEVANCE REVIEW FORM" (**DHS-38a**);
- "NOTICE OF REFERRAL TO SHELTER" (**DHS-39**);
- "CLIENT NOTICE OF SHELTER BED ASSIGNMENT SERVICES" (**DHS-39a**);
- "Single Adult Safe Permanent Housing Referral Notice" (**DHS-40**);
- "Single Adult Permanent Placement Referral Instructions" (**DHS-40a**);

- "Letter to Acknowledge Apartment Selected Does Not Meet The Department of Homeless Services Housing Referral Criteria" (**DHS-40b**);

- The following forms were created for the Client Responsibility process. All new CARES users, who are DHS Staff with dual roles, must complete and sign these form before they are granted access to the database."

    - "CARES Client Confidentiality and the Data Protection Policy Acknowledgement Form (Dual Roles DHS Staff)" (**DHS-41**);
    - "CARES Client Confidentiality and the Data Protection Policy Acknowledgement Form (DHS Staff)" (**DHS-41a**);
    - "CARES Client Confidentiality and the Data Protection Policy Acknowledgement Form (DHS Staff)" (**DHS-41b**.

■ REVISED FORMS

The following forms have been revised and updated on eDocs:

- "Rental Assistance Supplement: Potential Eligibility Letter" (**DSS-7**);
- "Potential Eligibility a Rental Assistance Supplement" (**DSS-7b**);
- "HCF-DHS Referral Form" (DHS-14) was revised to include the referral as part of the form.

■ REQUIRED ACTION

DHS staff and directors of shelters, safe havens, and drop-in centers must ensure that only the latest versions of forms (available on DHS intranet) are used and that all previous versions of the forms are removed from circulation and recycled.

Effective Immediately

■ ATTACHMENTS:

DHS-14	HCF-DHS Referral Form (06/26/2019)
DHS-25	Clinical Services Unit Permission to Administer Screenings to Adolescent Age 12-17 (05/22/2019)
DHS-25 (S)	Clinical Services Unit Permission to Administer Screenings to Adolescent Age 12-17 (05/22/2019)
DHS-25a	Clinical Services Unit Family Agreement (05/22/2019)
DHS-25a (S)	Clinical Services Unit Family Agreement (05/22/2019)
DHS-26	Shelter Application Withdrawal Form (05/29/2019)
DHS-26 (S)	Shelter Application Withdrawal Form (05/29/2019)
DHS-27	Appointment Notification (05/30/2019)
DHS-27 (S)	Appointment Notification (05/30/2019)
DHS-27a	Referral to Intake Center (05/30/2019)
DHS-27a (S)	Referral to Intake Center (05/30/2019)

DHS-29	ATTENTION ALL RESIDENCES (06/04/2019)
DHS-29 (S)	ATTENTION ALL RESIDENCES (06/04/2019)
DHS-30	Notice of Temporary Suspension of Shelter Services (06/04/2019)
DHS-30 (S)	Notice of Temporary Suspension of Shelter Services (06/04/2019)
DHS-31	Notice Regarding Locker Inspection (06/04/2019)
DHS-31 (S)	Notice Regarding Locker Inspection (06/04/2019)
DHS-31a	Notice Regarding Locker Inspection and Contraband (06/04/2019)
DHS-31a (S)	Notice Regarding Locker Inspection and Contraband (06/04/2019)
DHS-32	Notice of No Smoking Regulations and Suspension for Infractions (06/04/2019)
DHS-32 (S)	Notice of No Smoking Regulations and Suspension for Infractions (06/04/2019)
DHS-32a	NO SMOKING/OPEN FLAME POLICY (06/06/2019)
DHS-32a (S)	NO SMOKING/OPEN FLAME POLICY (06/06/2019)
DHS-33	Refusal of Shelter Bed Assignment (06/04/2019)
DHS-33 (S)	Refusal of Shelter Bed Assignment (06/04/2019)
DHS-34	DRUG TESTING CONSENT FORM (06/06/2019)
DHS-34 (S)	DRUG TESTING CONSENT FORM (06/06/2019)
DHS-35	RESIDENCY LETTER (06/06/2019)
DHS-35 (S)	RESIDENCY LETTER (06/06/2019)
DHS-36	Welcome to the Barbara Kleinman Shelter (06/06/2019)
DHS-36 (S)	Welcome to the Barbara Kleinman Shelter (06/06/2019)
DHS-36a	CATHERINE STREET ADULT RESIDENCE (06/06/2019)
DHS-36a (S)	CATHERINE STREET ADULT RESIDENCE (06/06/2019)
DHS-37	CLIENT STORAGE POLICY (06/06/2019)
DHS-37 (S	CLIENT STORAGE POLICY (06/06/2019)
DHS-38	CONSTITUENT GRIEVANCE FORM (06/07/2019)
DHS-38 (S)	CONSTITUENT GRIEVANCE FORM (06/07/2019)
DHS-38a	CONSTITUENT GRIEVANCE REVIEW FORM (06/07/2019)
DHS-38a (S)	CONSTITUENT GRIEVANCE REVIEW FORM (06/07/2019)
DHS-39	NOTICE OF REFERRAL TO SHELTER (06/07/2019)
DHS-39 (S)	NOTICE OF REFERRAL TO SHELTER (06/07/2019)
DHS-39a	CLIENT NOTICE OF SHELTER BED ASSIGNMENT SERVICES (06/07/2019)
DHS-39a (S)	CLIENT NOTICE OF SHELTER BED ASSIGNMENT SERVICES (06/07/2019)
DHS-40	Single Adult Safe Permanent Housing Referral Notice (06/07/2019)
DHS-40 (S)	Single Adult Safe Permanent Housing Referral Notice (06/07/2019)
DHS-40a	Single Adult Permanent Placement Referral Instructions (06/07/2019)
DHS-40a (S)	Single Adult Permanent Placement Referral Instructions (06/07/2019)
DHS-40b	Letter to Acknowledge Apartment Selected Does Not Meet The Department of Homeless Services Housing Referral Criteria (06/07/2019)
DHS-40b (S)	Letter to Acknowledge Apartment Selected Does Not Meet The Department of Homeless Services Housing Referral Criteria (06/07/2019)
DHS-41	CARES Client Confidentiality and the Data Protection Policy Acknowledgement Form (Dual Roles DHS Staff) (06/26/2019)
DHS-41a	CARES Client Confidentiality and the Data Protection Policy Acknowledgement Form (DHS Staff) (06/26/2019)

DHS-41b	CARES Client Confidentiality and the Data Protection Policy Acknowledgement Form (Provider) (06/26/2019)
DSS-7	Rental Assistance Supplement: Potential Eligibility Letter (07/09/2019)
DSS-7 (S)	Rental Assistance Supplement: Potential Eligibility Letter (07/09/2019)
DSS-7 b	Potential Eligibility a Rental Assistance Supplement (07/09/2019)
DSS-7b (S)	Potential Eligibility a Rental Assistance Supplement (07/09/2019)

Department of Homeless Services
Department of Social Services

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.

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

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;
- On a ventilator; or
- CD4 count below 200.

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

APPENDIX 1

Department of Social Services
Department of Homeless Services

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: 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:**
Over 30 day length of stay: Yes ◯ No ◯	**Expected Date of Discharge:**

APPENDIX 1

Department of Social Services
Department of Homeless Services

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: 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 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: _____	

Department of Social Services
Department of Homeless Services

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:**	0

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: Yes**	**No**	**Attempted date:**	**Justify inability to place patient in alternate housing:**
	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: ***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	◯ 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 ◯ 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):		
3.5	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): **DOB:** **CARES ID:**

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 *if known*:		
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): **DOB:** **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): **DOB:** **CARES ID:**

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	

Department of Social Services
Department of Homeless Services

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	N/A ☐
		Contact name:		Phone number/ email:		
	☐	Mental health appointment	Date	Time	Location	N/A ☐
		Contact name:		Phone number/ email:		
	☐	Substance use appointment	Date	Time	Location	N/A ☐
		Contact name:		Phone number/ email:		
	☐	Surgical follow-up appointment	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:		
6.2	Application made for Health Home				Yes ○ No ○	N/A ○
	Health Home care coordinator name:					N/A ☐
	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 ○
	Name of ACT team:			Borough of ACT team:		
	ACT team contact name and phone number/ email:					

APPENDIX 1

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

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

Department of Homeless Services
Department of Social Services

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

Department of Homeless Services
Department of Social Services

Clinical Services Unit
Permission to Administer Screenings to Adolescent Age 12-17

I, _____, authorize DHS' Clinical Services Unit Social Worker, _____, to administer the following screenings to my child, _____, Date of Birth: _____.

Mental Health:

PTSD screening to assess for possible symptoms of trauma.

PHQ-9 to assess for possible symptoms of depression.

Substance Abuse:

CRAFFT screening to assess for substance related risks and problems.

I understand that the purpose of completing the screenings is to assess for service needs for my child. I also understand that I can rebuke my consent at any time.

I understand that the screenings can be done in the presence of myself or another legal guardian. I also understand the recommendation that to illicit the most honest response, it is best that the Social Worker complete the screenings one on one with my child.

_____ _____

Signature of Guardian **Date**

_____ _____

Signature of Child (12 years and older) **Date**

_____ _____

Witness (Social Worker's Signature) **Date**

Department of Homeless Services
Department of Social Services

Unidad de Servicios Clínicos
Permiso para Evaluar Adolescentes entre 12 y 17 Años de Edad

Yo, _____, le autorizo al/la trabajador(a) social de la Unidad de Servicios Clínicos del Departamento de Servicios para Personas sin Viviendas (DHS, por sus siglas en inglés), _____, realizar las siguientes evaluaciones a mi hijo(a), _____, con fecha de nacimiento: _____.

Salud Mental:

Prueba de TEPT (PTSD, por sus siglas en inglés) para evaluar posibles síntomas de trauma.

Cuestionario sobre la salud del paciente (PHQ-9, por sus siglas en inglés) para evaluar posibles síntomas de depresión.

Abuso de sustancias:

Prueba CARLOS (CRAFFT, por sus siglas en inglés) para evaluar riesgos y problemas relacionados a sustancias.

Comprendo que el propósito de realizar estas pruebas es de evaluar los servicios necesarios para mi hijo(a). Comprendo además que puedo retirar mi consentimiento en cualquier momento.

Comprendo que las pruebas pueden ser realizadas en mi presencia o en presencia de otro(a) tutor(a) legal. También comprendo que, para fines de obtener respuestas honestas, se recomienda que el trabajador o trabajadora social realice las evaluaciones en privado.

_____ _____
Firma del tutor o tutora **Fecha**

_____ _____
Firma del menor (de 12 años y mayores) **Fecha**

_____ _____
Testigo (firma del trabajador[a] social) **Fecha**

Department of Homeless Services
Department of Social Services

Clinical Services Unit
Family Agreement

I am a Clinical Social Worker from the Department of Homeless Services (DHS)/Family Services Division - Clinical Services Unit. I have been assigned to work with you and your family while you are residing in shelter. I will be working collaboratively with you and your family to complete a Family Assessment to assess the strengths of your family and address any areas of need defined by you.

The goal of our work together will be to help prepare your family to exit shelter to permanent housing, with community resources in place that are necessary to sustain your independence. I will also provide advocacy to your family to address issues that may arise during your stay in shelter.

By gathering information to complete a Family Assessment, which includes administering Assessment Screening Tools, and with your buy-in and input, I will be providing you and your family with clinical, goal-oriented interventions, including the following:

- **Mental health/medical services referrals**
- **Childcare needs - Early Intervention or Daycare referrals**
- **Advocacy and Case Conferencing with community organizations including schools, ACS, and community clinics and hospitals**
- **Mediation and conferencing with you and shelter staff as needed**
- **Short-term counseling/Psychoeducation to address issues that may be affecting your family's functioning**

The length of our time working together will be approximately 4 months. We will initially meet weekly to complete the Family Assessment, and then either weekly or bi-weekly, depending on the needs of you and your family.

During our time together, I will be asking you to sign HIPAA consent forms for me to be able to collaborate with your providers to ensure we are working together to meet your needs.

This is a voluntary service, and you have the right to withdraw at any time.

_____ _____

Client Name (Print) Date

_____ _____

Social Worker Name (Print) Date

Department of Homeless Services
Department of Social Services

Unidad de Servicios Clínicos
Acuerdo Familiar

Yo soy un(a) trabajador(a) social clínico(a) del Departamento de Servicios para Personas sin Vivienda (DHS, por sus siglas en inglés)/División de Servicios Familiares – Unidad de Servicios Clínicos. Se me ha asignado para trabajar con usted y con su familia mientras vivan en el albergue. Yo colaboraré con usted y con su familia para realizar una evaluación familiar con fin de identificar los puntos fuertes de su familia y abordar cualquier área que necesite atención, según usted estime.

La meta de nuestro trabajo juntos será preparar a su familia para la salida del albergue hacia una vivienda permanente, contando con los recursos comunitarios necesarios para sostener su independencia. También le proporcionaré apoyo a su familia para abordar problemas que puedan surgir durante su estancia en el albergue.

Al obtener información para realizar la evaluación familiar, lo cual incluye utilizar los instrumentos de prueba para evaluación (Assessment Screening Tools) y con su colaboración y aporte, yo le proporcionaré a usted y a su familia intervención clínica, orientada al alcance de metas, que podría incluir lo siguiente:

- **Referencias para servicios médicos/de salud mental**
- **Necesidades de cuidado infantil – referencias para la intervención temprana o guardería infantil**
- **Apoyo y casos de conferencias con organizaciones comunitarias que incluye a escuelas, la Administración de Servicios para Niños (ACS, por sus siglas en inglés) y clínicas y hospitales comunitarios**
- **Mediación y conferencias con usted y el personal del albergue a medida que sea necesario**
- **Consejería/psicoeducación a corto plazo para abordar problemas que puedan estar afectando el funcionamiento familiar**

El plazo de tiempo en que trabajaremos juntos será de aproximadamente 4 meses. Primero nos reuniremos semanalmente para realizar la evaluación familiar y luego semanal o quincenalmente, dependiendo de sus necesidades y las de su familia.

Durante el tiempo en que colaboremos juntos, le pediré que me firme formularios de consentimiento de HIPAA para poder colaborar con sus proveedores y así asegurar el poder trabajar juntos para satisfacer sus necesidades.

Este es un servicio voluntario y usted tiene derecho a retirarse en cualquier momento.

Nombre del/de la cliente (en letra de molde)	Fecha
Nombre del trabajador(a) (en letra de molde)	Fecha

Department of Homeless Services
Department of Social Services

Shelter Application Withdrawal Form

I am withdrawing my application with the NYC Department of Homeless Services (DHS) for temporary housing assistance for myself and all persons on my application.

Case Number: _____ Application Date: _____ Case Type: _____

Case Members	CARES ID	Date Of Birth	Relationship to Head Of Case

PLEASE READ

I am voluntarily withdrawing my request for temporary housing assistance (shelter). I have been informed of and understand the Shelter Application Withdrawal process. I understand that I can re-apply for temporary housing assistance again at any time. I also agree to work with DHS or Department of Social Services diversion services to help me find stable housing, with the understanding that I can end those services at any time.

Diversion or Resource Room Contact

_____ _____

Staff Name (print) Telephone Number

Client Comments: If you would like to explain your decision to withdraw your application, please do so below. This is not required.

Application Withdrawn by:

_____ _____ _____

Client Name (print) Client Signature Date

Department of Homeless Services
Department of Social Services

Formulario para Retirar la Solicitud de Albergue

Retiro la solicitud presentada al Departamento de Servicios para Personas sin Vivienda de la ciudad de Nueva York (DHS, por sus siglas en inglés) para recibir asistencia de vivienda provisional, para mi y para todas las personas mencionadas en la solicitud.

Número de caso: _____ Fecha de solicitud: _____ Tipo de caso: _____

Integrantes del caso	Número de identificación de CARES	Fecha de nacimineto	Parentesco con el/la encargado(a) del caso

FAVOR DE LEER

Retiro de forma voluntaria mi petición para recibir asistencia de vivienda provisional (albergue). Se me ha informado y comprendo cómo funciona el trámite para retirar la solicitud de albergue. Comprendo que puedo volver a solicitar la asistencia de vivienda provisional en cualquier momento. También estoy de acuerdo con colaborar con el DHS o con la Unidad de Servicios para Desviación del Departamento de Servicios Sociales, para que me ayuden a encontrar una vivienda estable, bajo el entendimiento que puedo poner fin a esos servicios en cualquier momento.

Contacto en la Unidad de Desviación o Unidad de Recursos

_____ _____

Nombre del personal (en letra de molde) Número de teléfono

Comentarios del/de la cliente: Si le gustaría explicar su decisión de retirar su solicitud, favor de hacerlo a continuación. Esto no es requerido.

La solicitud es retirada por:

_____ _____ _____

Nombre del/de la cliente (en letra de molde) Firma del/de la cliente Fecha

Department of Homeless Services
Department of Social Services

Appointment Notification

Please attend this appointment. It is important that you arrive on-time and bring all information noted below. If you are unable to attend, contact your case worker or the meeting scheduler as soon as possible.

Head of Case:	CARES ID:
Case Number:	Case Triage Date:

Appointment Date: _____ Appointment Start Time: _____

Appointment End Time: _____

Appointment Type: _____

Concerning: _____

Location Name: _____

Location Address: _____

Meeting Scheduled by: _____ _____

Name Telephone Number

Appointment Needs and Expectations:

Additional Information, if required:

Appointment Slip: ☐ First Issued ☐ Second Issued

Service Rendered: ☐ In Person ☐ Under Facility Door

Appointment Scheduled On: _____

_____ _____
Applicant's Signature Date

_____ _____
Supervisor's Signature Date

_____ _____
Investigator's Signature Date

Appointment Status:

☐ Applicant did not respond to Appointment Slip

☐ Applicant responded to Appointment Slip

_____ _____
Supervisor's Signature Date

Department of Homeless Services
Department of Social Services

Notificación de Cita

Favor de presentarse a esta cita. Es importante llegar puntual y traer toda la información indicada abajo. Si no puede presentarse, comuníquese con el/la trabajador(a) del caso o con el/la programador(a) de citas lo antes posible.

Encargado(a) del caso:	Número de identificación de CARES:
Número de caso:	Fecha de clasificación del caso:

Fecha de la cita: _____ Inicio de la cita: _____ _____

Fin de la cita: _____ _____

Tipo de cita: _____

Con relación a: _____

Nombre del lugar: _____

Dirección del lugar: _____

Cita programada por: _____ _____

Nombre Número de teléfono

Necesidades y expectativas de la cita:

Información adicional, si es requerida:

Comprobante de citas: ☐ Primer comprobante ☐ Segundo comprobante

Entrega del comprobante: ☐ En persona ☐ Por debajo de la puerta del albergue

Cita programada el: _____

Firma del/de la solicitante _____ Fecha _____

Firma del supervisor/de la supervisora _____ Fecha _____

Firma del investigador/de la investigadora _____ Fecha _____

Estado de la cita:

☐ El cliente/la clienta no respondió al comprobante de citas

☐ El cliente/la clienta respondió al comprobante de citas

Firma del supervisor/de la supervisora _____ Fecha _____

Department of Homeless Services
Department of Social Services

Referral to Intake Center

Client: _____ CARES ID: _____

Referring Shelter: _____

Referral Date: _____ Referral Time: _____ _____

Referral Created By: _____

Please go to the intake center checked below to request shelter or other services from the New York City Department of Homeless Services (DHS).

Intake Centers

- ☐ 30th Street Men's Intake Center (Bellevue), 400 – 430 East 30th Street, Manhattan
- ☐ Adult Family Intake Center (AFIC), 400 – 430 East 30th Street, Manhattan
- ☐ Family Intake Center (PATH), 151 East 151st, Bronx
- ☐ HELP Women's Intake Center, 116 Williams Avenue, Brooklyn
- ☐ Franklin Women's Intake Center, 1122 Franklin Avenue, Bronx

PLEASE BRING THIS NOTICE WITH YOU

Intake Center Locations, Contact Information, and Directions:

30th STREET MEN'S INTAKE CENTER 400-430 East 30th Street, Manhattan (212) 701-4300 Open 24 hours, 7 days per week.	Entrance on 30th Street just east of 1st Avenue. **Subway:** 6 train to 28th Street. Walk east to 1st Avenue, turn left, and head north to 30th Street. **Bus:** M15 to 29th Street.
ADULT FAMILY INTAKE CENTER (AFIC) 400-430 East 30th Street, Manhattan (212) 481-4704 Open 24 hours, 7 days per week.	Entrance on 30th Street just east of 1st Avenue. **Subway:** 6 train to 28th Street. Walk east to 1st Avenue, turn left, and head north to 30th Street. **Bus:** M15 to 29th Street.

Intake Center Locations, Contact Information, and Directions *(continued)*:

FAMILY INTAKE CENTER (PATH) 151 East 151st, Bronx (718) 503-6400 Open 24 hours, 7 days per week.	Entrance on 151st Street between Walton and Gerard Avenues. **Subway:** Take the 2, 4, or 5 train to 149th Street/Grand Concourse Station. Head west to Grand Concourse. Walk north on Grand Concourse two blocks to East 151st Street and turn left. Walk two blocks to Walton Avenue.
HELP WOMEN'S INTAKE CENTER 116 Williams Avenue, Brooklyn (718) 483-7700 Open 24 hours, 7 days per week.	Located between Glenmore and Liberty Avenue in East New York, Brooklyn. **Subway:** C train to Liberty Avenue, or L train to Atlantic Avenue.
FRANKLIN WOMEN'S INTAKE CENTER 1122 Franklin Avenue, Bronx (929) 281-2330 Open 24 hours, 7 days per week.	Located at corner of Franklin Avenue and East 166th Street in the Franklin Avenue Armory building. **Subway:** 2 train to 149th Street, followed by the #55 bus to 166th Street and 3rd Avenue.

Department of Homeless Services
Department of Social Services

Referencia para el Centro de Registro

Cliente(a): _____ Identificación de CARES: _____

Alberque que refiere: _____

Fecha de referencia: _____ Hora de referencia: _____ _____

Referencia creada por: _____

Favor de ir al centro de registro marcado a continuación para pedir albergue u otros servicios del Departamento de Servicios para Personas sin Vivienda de la ciudad de Nueva York (DHS, por sus siglas en inglés).

Centros de registro

- ☐ 30th Street Men's Intake Center (Bellevue), 400 – 430 East 30th Street, Manhattan
- ☐ Adult Family Intake Center (AFIC), 400 – 430 East 30th Street, Manhattan
- ☐ Family Intake Center (PATH), 151 East 151st, Bronx
- ☐ HELP Women's Intake Center, 116 Williams Avenue, Brooklyn
- ☐ Franklin Women's Intake Center, 1122 Franklin Avenue, Bronx

FAVOR DE LLEVAR ESTE AVISO CON USTED

Ubicación, información de contacto e indicaciones de viaje de los centros de registro:

30th STREET MEN'S INTAKE CENTER **Centro de registro para hombres** 400-430 East 30th Street, Manhattan (212) 701-4300 Abierto las 24 horas, 7 días a la semana.	Entrada por la calle 30th Street, en dirección este, hacia la primera avenida (1st Avenue). **Por tren:** Tren 6 hasta la estación 28th Street. Camine hacia el este, hasta llegar a 1st Avenue, gire a la izquierda y diríjase hacia el norte hasta llegar a 30th Street. **Por autobus:** M15 hasta llegar a la calle 29th Street.
ADULT FAMILY INTAKE CENTER (AFIC) **Centro de registro para familias compuetas por adultos** 400-430 East 30th Street, Manhattan (212) 481-4704 Abierto las 24 horas, 7 días a la semana.	Entrada por la calle 30th Street, en dirección este, hacia la primera avenida (1st Avenue). **Por tren:** Tren 6 hasta la estación 28th Street. Camine hacia el este hasta llegar a 1st Avenue, gire a la izquierda y diríjase hacia el norte hasta llegar a 30th Street. **Por autobus:** M15 hasta llegar a la calle 29th Street.

Ubicación, información de contacto e indicaciones de viaje para los centros de registro (*continuación*):

FAMILY INTAKE CENTER (PATH) **Centro de registro para familias con menores** 151 East 151st, Bronx (718) 503-6400 Abierto las 24 horas, 7 días a la semana.	Entrada por la calle 151st Street, entre las avenidas Walton y Gerard. **Por tren:** Tomar el tren 2, 4, o 5 hasta la estación de la 149th Street/Grand Concourse. Diríjase hacia el oeste en dirección a Grand Concourse. Camine 2 cuadras hacia el norte en Grand Concourse hasta la calle East 151st Street y gire a la izquierda. Camine dos cuadras hasta llegar a Walton Avenue.
HELP WOMEN'S INTAKE CENTER **Centro de registro para mujeres** 116 Williams Avenue, Brooklyn (718) 483-7700 Abierto las 24 horas, 7 días a la semana.	Ubicado entre las avenidas Glenmore y Liberty, en East New York, Brooklyn. **Por tren:** Tomar el trenC hasta la estación Liberty Avenue o el tren L hasta la estación Atlantic Avenue.
FRANKLIN WOMEN'S INTAKE CENTER **Centro de registro para mujeres** 1122 Franklin Avenue, Bronx (929) 281-2330 Abierto las 24 horas, 7 días a la semana.	Ubicado en la esquina de Franklin Avenue y la calle 166, en el edificio Armory de Franklin Avenue. **Por tren**: Tomar el tren hasta la estación 149th Street. Tomar el autobus #55 hasta la calle 166 y la tercera avenida (3rd Avenue).

Department of Homeless Services
Department of Social Services

DHS-29 (E) 06/04/2019 LLF

ATTENTION ALL RESIDENTS

CURFEW AT ALL ADULTS SHELTERS IS 10:00 PM.

CURFEW IS STRICTLY ENFORCED.

YOU MUST RETURN TO YOUR ASSIGNED SHELTER AND SIGN FOR YOUR BED BY 10:00 PM OR YOU WILL LOSE YOUR BED.

If you violate curfew, you will be assigned to a Temporary Shelter where you will sleep until a bed is available at your Official Shelter. You are expected to return to your Official Shelter to get another bed, meals and other services as soon as there is a vacancy.

If you must return later than 10:00 PM because you are working, etc., you must get a late pass from your caseworker in advance.

If you have an emergency and cannot return to the shelter by 10:00 PM, call the shelter and tell the Night Supervisor that you will return and why you will be late.

THE SHELTER DOORS WILL BE CLOSED AT 10:00 PM.

YOU MAY ENTER AFTER 10:00 PM ONLY WITH A VALID LATE PASS, REFERRAL OR TRANSFER.

Department of Homeless Services
Department of Social Services

ATENCIÓN A TODOS LOS RESIDENTES

EL TOQUE DE QUEDA INCIA A LAS 10:00 PM EN LOS ALBERGUES PARA ADULTOS.

EL TOQUE DE QUEDA SE HACE CUMPLIR ESTRICTAMENTE.

USTED TIENE QUE VOLVER AL ALBERGUE ASIGNADO Y FIRMAR PRESENTE A LAS 10:00 PM A MÁS TARDAR, DE LO CONTRARIO, USTED PERDERÁ SU CAMA.

Si no cumple el horario del toque de queda, se le asignará a un albergue provisional donde dormirá hasta que se desocupe una cama en su albergue oficial. Se espera que usted pueda volver a su albergue oficial para obtener cama, comidas y otros servicios tan pronto haya una vacante.

Si tiene que volver después de las 10:00 PM debido a que tiene que trabajar, etc., usted tiene que obtener por anticipado un permiso de tardanza por medio al/la trabajador(a) del caso.

Si tiene alguna emergencia y no puede volver al albergue antes de las 10:00 PM, llame al albergue y dígale al/la supervisor(a) que usted sí regresará y explíquele el motivo por el cual volverá tarde.

LAS PUERTAS DEL ALBERGUE SE CERRARÁN A LAS 10:00 PM.

USTED PODRÁ ENTRAR DESPUÉS DE LAS 10:00 PM SOLO SI TIENE A MANO UN PERMISO VÁLIDO DE TARDANZA, UNA REFERENCIA O POR UN TRASLADO.

Department of Homeless Services
Department of Social Services

Notice of Temporary Suspension of Shelter Services

Client Last Name:	Client First Name:	CARES ID:
Client Preferred Name:	Client Gender Pronoun(s):	
Suspending Shelter:	Date of Suspension:	

This is to inform you that you will not be able to access shelter services provided by the New York City Department of Homeless Services for _____ days. During this time, however, you are able to access services at all Drop-In Centers.

REASON FOR SUSPENSION

The reason your shelter services have been temporarily suspended is that, after an investigation, it was determined _____ that on in or around the shelter, you engaged in an act
Date Time

prohibited by shelter regulations (check one):

- ☐ Arson/vandalism of facility/equipment in or around the shelter.
- ☐ Possession/sale/use of illegal drugs or alcohol in or around the shelter.
- ☐ Violent/assaultive/dangerous behavior/weapons in or around the shelter.
- ☐ Arrest for criminal activity including, but not limited to trespassing, theft harassment, extortion loan sharking, intimidation or victimization of clients or staff in or around the shelter.
- ☐ Smoking in unauthorized shelter areas.
- ☐ Other

Description/Comments: _____

_____

_____

_____

(Turn Page)

Suspension begins:	You may reapply for shelter on:

Services will not necessarily be reinstated at the same shelter from which you were suspended.

Client Signature _____ Date _____

Supervisor Signature _____ Date _____

Supervisor Name (print) _____

Department of Homeless Services
Department of Social Services

Aviso de Suspensión Provisional de los Servicios de Albergue

Apellido del cliente/de la clienta:	Nombre del cliente/de la clienta:	Número de identificación de CARES:
Nombre que prefiere el cliente/la clienta:	Pronombre(s) de género que prefiere el cliente/ la clienta:	
Albergue que emite la suspensión:	Fecha de suspensión:	

Este aviso es para informarle que usted no tendrá acceso a los servicios de albergue proporcionados por el Departamento de Servicios para Personas sin Vivienda de la ciudad de Nueva York durante _____ días. Sin embargo, durante este tiempo usted podrá tener acceso a los servicios proporcionados en todos los centros de puertas abiertas.

MOTIVO DE LA SUSPENSIÓN

El motivo por el cual se han suspendido provisionalmente sus servicios de albergue es porque después de realizar una investigación, se determinó que el _____ (Fecha) _____ (Hora) en el albergue o en sus alrededores, usted participó en un acto prohibido por las normas del albergue (marcar uno):

- ☐ Incendio provocado/vandalismo de las instalaciones/del equipo en el albergue o en sus alrededores.
- ☐ Tenencia/venta/uso ilegal de narcóticos o de alcohol, en el albergue o en sus alrededores.
- ☐ Comportamiento violento/peligroso/agresión/portar armas en el albergue o en sus alrededores.
- ☐ Arresto por actividad delictiva, que incluye pero no se limita a la invasión de la propiedad privada, acoso, robo, extorción, préstamos ilegales, intimidación o victimización de clientes o del personal, en el albergue o en sus alrededores.
- ☐ Fumar en áreas no autorizadas del albergue.
- ☐ Otro

Descripción/comentarios: _____

_____

_____

_____

(Voltee la página)

La suspensión se inicia el:	Usted puede volver a solicitar el:

Los servicios no se reestablecerán necesariamente en el mismo albergue del cual fue suspendido.

Firma del cliente/de la clienta

Fecha

Firma del supervisor/de la supervisora

Fecha

Nombre del supervisor/de la supervisora
(en letra de molde)

Department of Homeless Services
Department of Social Services

DHS-31 (E) 06/04/2019 LLF

Notice Regarding Locker Inspection

Shelter Name: _____ Date: _____/_____/_____

Client Last Name:	Client First Name:	CARES ID:
Client Preferred Name:	Client Gender Pronoun(s):	
Bed Number:	Locker Number:	

On _____ at _____ AM/PM, your locker was opened. Its
(date) (time)
contents were inspected by shelter and security staff.

If you have any questions about this inspection, please speak with the shelter staff named below or the supervisor on duty.

Supervising Shelter Staff	
Staff Name (print)	Staff Signature
Staff Title	Date

Supervising Security Staff	
Staff Name (print)	Security Staff Signature
Staff Title	Date

Department of Homeless Services
Department of Social Services

Aviso sobre la Inspección de Casilleros

Nombre del albergue:_____ Fecha: _____/ ____/ _____

Apellido del cliente/de la cliente:	Nombre del cliente/de la cliente:	Identificación de CARES:
Nombre preferido del cliente/de la cliente:	Pronombres de género del cliente/de la cliente:	
Número de cama:	Número de casillero:	

El día _____ a las _____ a.m./p.m. su casillero fue abierto.
(fecha) (hora)

El contenido fue inspeccionado por el personal del albergue y de seguridad.

Si tiene alguna pregunta sobre esta inspección, comuníquese con el miembro del personal de albergue mencionado(a) que sigue a continuación o con el supervisor/la supervisora de turno.

Personal de supervisión del albergue

Nombre del miembro del personal (en letra de molde)	Firma del miembro del personal
Cargo del miembro del personal	Fecha

Personal de supervisión de seguridad

Nombre del miembro del personal (en letra de molde)	Firma del miembro del personal de seguridad
Cargo del miembro del personal	Fecha

Department of Homeless Services
Department of Social Services

Notice Regarding Locker Inspections and Contraband

The locker assigned to you can be opened and inspected by shelter staff pursuant to agency procedures.

Contraband items found in lockers will be removed.

Possession of contraband while in shelter may result in arrest, suspension of services for up to seven days, or temporary discontinuance of shelter services for 30 days.

You are forbidden to possess in shelter, or store in your locker, the following:

- Weapons, including guns, knives, brass knuckles, and firearm ammunition
- Dangerous instruments and materials, including sticks, bats, scissors, ice picks, box cutters, caustic chemicals, flammable liquids, and fireworks
- Hazardous tools and utensils, including hammers, screwdrivers, and carving forks. If you have tools you need for employment or training, please talk to your case manager.
- Replicas of weapons
- Illegal drugs and drug paraphernalia including K-2, Spice, " Synthetic Marijuana," and similar products
- Alcoholic beverages
- Electrical appliances, including hotplates, hairdryers, and electric heater
- Incense and candles

Aviso sobre Inspecciones de Casilleros y Contrabando

El casillero que se le ha asignado puede ser abierto e inspeccionado por el personal del albergue, conforme a los procedimientos de la agencia.

Los artículos de contrabando hallados en los casilleros serán retirados.

La tenencia de artículos de contrabando durante la estadía en el albergue puede resultar en el arresto, la suspensión de servicios por un máximo de siete días o en la interrupción provisional de los servicios de albergue, durante 30 días.

Se le prohíbe tener en el albergue o guardar en su casillero lo siguiente:

- Armas, incluyendo pistolas, cuchillos, manoplas y munición para armas de fuego
- Instrumentos y materiales peligrosos, incluyendo palos, bates, tijeras, picahielos, cúteres, sustancias cáusticas, líquidos inflamables y fuegos artificiales
- Herramientas o utensilios peligrosos, incluyendo martillos, destornilladores y tenedores de trinchar. Si tiene herramientas que necesita para el empleo o capacitación, favor de conversar con su administrador de casos.
- Réplicas de armas
- Narcóticos ilegales y parafernalia de drogas, incluyendo las drogas K-2, “Spice”, marihuana sintética y productos similares
- Bebidas alcohólicas
- Electrodomésticos, incluyendo hornillos, secadoras de pelo y calentadores eléctricos
- Inciensos y velas

Department of Homeless Services
Department of Social Services

Notice of No Smoking Regulations and Suspension for Infractions

Shelter Name: _____ Date: _____/ _____/ _____

Client Last Name:	Client First Name:	CARES ID:
Client Preferred Name:	Client Gender Pronoun(s):	

If I am observed smoking or using a flame in sleeping areas, I may be suspended from the shelter system for up to 7 days.

If I return to shelter after my suspension, I will be assigned to another bed, if one is available, or will be transferred to another shelter.

I will be given warnings for the 1st and 2nd infraction, and I will be assigned to another bed, if one is available, if:

- Evidence of smoking (cigarette butts, burn marks, burned matches, ashes, etc.) is observed near my bed while I am in the room, or
- I am observed smoking or using a flame in areas other than sleep areas (hallways, bathrooms, etc.)

On the 3rd and subsequent time there is evidence of smoking near my bed or I am observed smoking or using a flame in an unauthorized area other than a sleeping area, I may be immediately suspended for up to 7 days.

_____ _____

Client Signature Date

(Turn Page)

FOR DHS STAFF USE ONLY

I have explained this form to the client.

☐ Issued to Client ☐ Client refused to sign ☐ 1st Warning ☐ 2nd Warning

Staff Name (print) _____ Staff Signature _____

Staff Title _____ Date _____

Department of Homeless Services
Department of Social Services

Aviso sobre el Reglamento de No Fumar y sobre la Suspensión por Infracciones

Nombre del albergue: _____ Fecha: _____/ _____/ _____

Apellido del cliente/de la cliente:	Nombre del cliente/de la cliente:	Identificación de CARES:
Nombre preferido del cliente/de la cliente:	Pronombres de género del cliente/de la cliente:	

Si se me observa fumando o utilizando una llama encendida en las áreas para dormir, podría ser suspendido(a) del sistema de albergues, por hasta 7 días.

Si regreso al albergue una vez finalizada mi suspensión, se me asignará otra cama, si hay alguna disponible, o se me trasladará a otro albergue.

Recibiré advertencias por la primera y segunda infracción, y se me asignará otra cama si hay alguna disponible, si:

- se observa evidencia de haber fumado (colillas de cigarrillos, quemaduras, fósforos usados, cenizas, etc.) cerca de mi cama, mientras yo esté en la habitación; o
- se me observa fumando o utilizando una llama encendida en las áreas fuera de los dormitorios (pasillos, baños, etc.)

La tercera vez y las veces subsiguientes que se encuentre evidencia de haber fumado cerca de mi cama, o si me observa fumando o utilizando una llama encendida en un área no autorizada, fuera de las áreas para dormir, podría ser suspendido(a) de inmediato, por hasta 7 días.

_____ _____

Firma del cliente/de la clienta Fecha

(Voltee la página)

FOR DHS STAFF USE ONLY

I have explained this form to the client.

☐ Issued to Client ☐ Client refused to sign ☐ 1st Warning ☐ 2nd Warning

Staff Name (print) _____ Staff Signature _____

Staff Title _____ Date _____

Department of Homeless Services
Department of Social Services

Division of Adult Services
Kingsboro STAR Men's Shelter
599 Clarkson Avenue, Building #5
Brooklyn, NY 11203

NO SMOKING/OPEN FLAME POLICY

We will **NOT** tolerate cigarette butts, ashes or burned matches near or around your sleeping area or common areas.

There is **NO** authorized smoking area within Kingsboro STAR.

Smoking or using an open flame will result in a 7-day suspension.

Client Signature _____ Date _____

Witness Signature _____ Date _____

Department of Homeless Services
Department of Social Services

División de Servicios para Adultos

Albergue para hombres Kingsboro STAR

599 Clarkson Avenue, Building #5

Brooklyn, NY 11203

POLÍTICA DE NO FUMAR/LLAMA ENCENDIDA

NO toleraremos colillas de cigarrillos, cenizas o fósforos quemados cerca o alrededor del área de dormir o de las áreas comunes.

NO hay áreas autorizadas para fumadores dentro del albergue Kingsboro STAR.

El fumar o utilizar llama encendida resultará en una suspensión de 7 días.

Firma del cliente _____ Fecha _____

Firma del testigo _____ Fecha _____

Department of Homeless Services
Department of Social Services

Refusal of Shelter Bed Assignment

Client Last Name:	Client First Name:	CARES ID:
Client Preferred Name:	Client Gender Pronoun(s):	
Assigned Shelter Name:	Assigned Shelter Address:	
Date of Shelter Bed Assignment:	Time of Shelter Bed Assignment:	

I refuse to accept the shelter bed offered to me at the shelter named above. I understand that by refusing to accept the bed assignment, I may be asked to leave the facility, especially if I have repeatedly refused a bed assignment in the past. I also understand that if I request shelter services in the future, I will be sent to the shelter named above if it is to be my official shelter, or to another shelter if an official or appropriate shelter does not have a vacancy at that time.

Client Signature _____ Date _____

FOR DHS STAFF USE ONLY

I have explained this form to the client. ☐ Client refused to sign

Staff Name (print) _____ Staff Signature _____

Staff Title _____ Date _____

Department of Homeless Services
Department of Social Services

Rechazo de Asignación de Cama en Albergue

Apellido del cliente/de la cliente:	Nombre del cliente/de la cliente:	Identificación de CARES:
Nombre preferido del cliente/de la cliente:	Pronombres de género del cliente/de la cliente:	
Nombre del albergue asignado:	Dirección del albergue asignado:	
Fecha de asignación de cama en el albergue:	Hora de asignación de cama en el albergue:	

Me niego a aceptar la cama ofrecida en el albergue indicado arriba. Comprendo que, al negarme a aceptar la cama asignada, puede que se me pida abandonar las instalaciones, especialmente si he rechazado repetidamente camas asignadas anteriormente. También comprendo que, si solicito servicios de albergue en el futuro, se me enviará al albergue indicado arriba, si ese es mi albergue oficial, o a otro albergue, en caso de que mi albergue oficial o el otro albergue adecuado no tuviesen vacantes en ese momento.

Firma del cliente/de la cliente: _____ Fecha _____

FOR DHS STAFF USE ONLY

I have explained this form to the client. ☐ Client refused to sign

Staff Name (print) _____ Staff Signature _____

Staff Title _____ Date _____

Department of Homeless Services
Department of Social Services

DRUG TESTING CONSENT FORM

Client Last Name:	Client First Name:
CARES ID:	Date of Birth:
Client Preferred Name:	Client Gender Pronoun(s):
Shelter Name:	Address:

By signing this Consent Form, I am indicating that I have read this Consent Form (or this Form has been read to me), and I understand its contents, and voluntarily consent to submit to a drug and alcohol testing upon the request of authorized shelter staff to determine whether drugs, alcohol or chemical intoxicants (referred to below as "drug/alcohol") are present in my system.

I understand the following:

- The purpose of drug/alcohol testing is to ensure a drug/alcohol-free and safe shelter environment, detect substance abuse or relapse, monitor progress toward achieving sobriety, and measure effectiveness of treatment.
- Drug/alcohol testing includes my submission to a urine test {under staff supervision} or Breathalyzer test upon the request of authorized shelter staff to determine whether drug/alcohol is present in my system.
- Drug use for which I will be tested does **not** include prescribed medication, which are documented by a prescription or other appropriate writing.
- Shelter staff will document my drug/alcohol test results in my case record, which will be shared with the NYC Department of Homeless Services (DHS) and other government agencies as permitted by applicable law.
- I can ask my shelter caseworker at any time for a copy of my drug/alcohol test results.

(Turn page)

- I can refuse to sign this Consent Form. Such refusal will **not** result in denial or discontinuance of shelter, my suspension from shelter, or the imposition of a First Independent Living Plan (ILP) Violation or Sanction against me.
- If I test positive for drug/alcohol use, I may be transferred to another shelter or referred to an out-patient or residential drug treatment program or other suitable housing that specializes in the treatment of substance abusers.
- I may need to take a drug/alcohol test to qualify for certain permanent housing placements.
- After signing this Consent Form, I can change my mind and revoke my consent to submit to a drug/alcohol test by signing a consent revocation form supplied by my case manager.

Client Signature _____ Date _____

Witness Signature _____ Date _____

Department of Homeless Services
Department of Social Services

FORMULARIO DE CONSENTIMIENTO PARA PRUEBAS DE DROGAS

Apellido del cliente/de la clienta:	Nombre del cliente/de la clienta:
Identificación de CARES:	Fecha de nacimiento:
Nombre de preferencia del cliente/de la clienta:	Pronombres de género del cliente/de la clienta:
Nombre del albergue:	Dirección:

Al firmar este formulario de consentimiento, estoy indicando que lo he leído (o que se me ha leído este formulario), comprendo su contenido y de manera voluntaria doy mi consentimiento para someterme a una prueba de drogas y de alcohol, a solicitud del persona autorizado del albergue, para determinar si hay drogas, alcohol o químicos intoxicantes (referidos a continuación como "drogas/alcohol") presentes en mi sistema.

Comprendo lo siguiente:

- El propósito de las pruebas de drogas/alcohol es asegurar un ambiente seguro y libre de drogas/alcohol, es detectar el abuso de sustancias o la recaída, monitorear el progreso hacia el logro de la sobriedad y medir la efectividad del tratamiento.
- La prueba de drogas/alcohol incluye el someterme a una prueba de orina {bajo supervisión del personal} o a una prueba de alcoholímetro, a solicitud del personal autorizado del albergue, para determinar si hay drogas/alcohol presentes en mi sistema.
- La prueba de uso de drogas a la que me someteré **no** incluye medicamentos recetados, los cuales están documentados en una receta u otro escrito apropiado.
- El personal del albergue documentará los resultados de mis pruebas de drogas/alcohol en el registro de mi caso, que se compartirá con el Departamento de Servicios para Personas sin Vivienda (DHS, por sus siglas en inglés) de la ciudad de Nueva York y otras agencias gubernamentales según lo permita la ley correspondiente.
- Puedo pedirle en cualquier momento al trabajador de casos del albergue una copia de los resultados de mi prueba de drogas/alcohol.

(Voltee la página)

- Puedo negarme a firmar este formulario de consentimiento. Dicho rechazo **no** resultará en la negación o la interrupción del albergue, en mi suspensión del albergue ni en la imposición de una violación del Plan de Vida Independiente (ILP, por sus siglas en inglés) o de una sanción en mi contra.

- Si el resultado de la prueba de uso de drogas/alcohol es positivo, se me podría trasladar a otro albergue o ser referido(a) a un programa de tratamiento de drogas ambulatorio o interno, o ser referido(a) a otra vivienda adecuada donde se especialicen en el tratamiento de personas que abusan sustancias.
- Es posible que deba hacerme una prueba de drogas/alcohol para calificar para ciertos tipos de colocaciones de vivienda permanente.
- Después de firmar este formulario de consentimiento, puedo cambiar de opinión y revocar mi consentimiento para someterme a una prueba de drogas/alcohol firmando un formulario de revocación de consentimiento proporcionada por mi administrador(a) de casos.

Firma del cliente/de la clienta: _____ Fecha _____

Firma del/de la testigo _____ Fecha _____

Department of Homeless Services
Department of Social Services

RESIDENCY LETTER

Date: _____

To whom it may concern:

Please be advised that _____ (CARES ID Number_____)
(Client Name)

is currently a resident at _____, and has been a
(Shelter Name)

resident since _____.

If you require additional information, please feel free to contact me at the number below.

Thank you for your cooperation and assistance in this matter.

Sincerely,

_____
Shelter Staff Signature

_____
Shelter Staff Name (Print)

_____
Shelter Staff Title

_____
Shelter Staff Telephone Number

Department of Homeless Services
Department of Social Services

CARTA DE RESIDENCIA

Fecha: _____

A quien corresponda:

Favor de tomar nota de que _____ (número de identificación de
(nombre del cliente)
CARES _____) reside actualmente en _____ y
(nombre del albergue)
ha sido residente desde _____.

Si necesita más información, no dude en comunicarse conmigo llamando al teléfono que se indica abajo.

Gracias por su colaboración y ayuda en cuanto a este tema.

Atentamente,

_____
Firma del personal del albergue

_____
Nombre del personal del albergue (en letra de molde)

_____
Cargo del personal del albergue

_____
Teléfono del personal del albergue

Department of Homeless Services
Department of Social Services

Division of Adult Services
Barbara Kleinman Residence
300 Skillman Avenue
Brooklyn, NY 11211

Welcome to the Barbara Kleinman Shelter!

Please keep this document for your records.

Your **case manager** is on the 1st floor in the Social Services Office.

- The office is open Sunday through Saturday.
- Your case manager is: _____.
- Ask your case manager for their hours.

1st Floor: **24 Hour Operations Office** – there is a supervisor on every shift.

- **24 Hour Desk: 718-963-3800**

2nd Floor: **Cafeteria**

- Breakfast – 6:30 AM
- Lunch – 12:00 PM
- Dinner – 5:30 PM

Medical Services are provided by Lutheran Medical Center.

- They are found at the front entrance.
- They are open Monday – Friday from 9:00 AM to 5:00 PM

Please read and comply with DHS shelter rules and regulations to make the outcome of your stay successful.

- **Leave the Dormitory floors before 9:00 AM.**
- **Shelter Curfew is 10:00 PM.**

Department of Homeless Services
Department of Social Services

División de Servicios para Adultos
Barbara Kleinman Residence
300 Skillman Avenue
Brooklyn, NY 11211

¡Bienvenido al Albergue Barbara Kleinman!

Guarde este documento en sus archivos.

Su **administrador de casos** está en el primer piso de la Oficina de Servicios Sociales.

- La oficina está abierta de domingo a sábado.
- Su administrador de casos es: _____.
- Pregunte a su administrador de casos cuál es su horario de trabajo.

1. ° piso: **Oficina de atención las 24 horas**: hay un(a) supervisor(a) en cada turno.
   - **Recepcionista las 24 horas: 718-963-3800**

2.° piso: **Cafetería**

- Desayuno: 6:30 a.m.
- Almuerzo: 12:00 p.m.
- Cena: 5:30 p.m.

Los **servicios médicos** son proporcionados por Lutheran Medical Center.

- El consultorio está en la entrada principal.
- Está abierto de lunes a viernes, de 9:00 a.m. a 5:00 p.m.

Favor de leer y cumplir las reglas y normas del albergue del DHS para que su estadía sea exitosa.

- **Salga de los pisos de dormitorios antes de las 9:00 a.m.**
- **El toque de queda del albergue inicia a las 10:00 p.m.**

Department of Homeless Services
Department of Social Services

CATHERINE STREET ADULT RESIDENCE

Welcome to the Catharine Street Adult Residence

Your Case Manager is in room 209. They will schedule an appointment to complete an Intake and Assessment with you within 2 days of your arrival.

Your Case Manager will work with you to develop a strategy of how you will exit shelter. They will work around your work/school activities and schedule meetings every two weeks to update your Independent Living Plan (ILP). At times, you may be required to meet more frequently.

- The **Supervisory staff** are located in rooms **214** and **210.**
- The **Director of Operation** is located in room **215.**
- The **Shelter Director** is located in room **213.**

Please note:

- Every person **must** sign in and out each time you enter and exit the facility.
- Residents **must** sign the Nightly Roster between **8:00 PM** and **10:00 PM** each evening. Those clients who work must provide documentation to their Case Manager in order to obtain a Late Pass. Failure to sign the Nightly Roster on a **nightly basis** will result in being logged out of the facility.
- The Social Services staff conducts **weekly** unit inspections to ensure the safety and cleanliness of your unit. **Please be aware that we will enter your unit whether or not you are present to do the inspections.** If we enter and you are not present, a note will be left to inform you.
- Units are exterminated weekly. To ensure that the facility is free of vermin, you must keep your unit clean and clutter free. This means no open food containers and/or garbage are to be left in the unit overnight. Floors must be swept and mopped regularly. Please use the receptacle on each floor, littering is unacceptable. With your help, we will keep the facility clean.
- You are able to bring in cleaning supplies such as plastic mops and plastic brooms, Pine Sol, Mop 'N Glo, and other disinfectants that do not contain bleach. You are **not** permitted to bring any bleach, ammonia or aerosol cans into the facility.

(Turn page)

- Linen is exchanged twice each week on **Wednesday** and **Thursday from 10:30 AM – 12:45 PM** and **6:00PM – 7:00 PM.** Dirty linen must be dropped off at Room 100.

- Supplies are distributed on **Tuesday and Thursdays** in room 100 from **10:30 AM – 12:00 PM** and **8:00 PM – 9:30 PM.** They consist of toilet paper, soap, and sanitary napkins.

- If you have maintenance issues with the unit, please inform your worker.

- Bathrooms are shared. However, there are designated female facilities on the first and second floor. They are cleaned several times a day; if you find a bathroom in need of cleaning, please bring it to the ASW's attention. With your help, we will keep the facility clean.

- The cafeteria is located on the first floor. Meal times are Sunday through Saturday as follows: **Breakfast 7:00 AM – 9:00 AM, Lunch 12:00 PM – 1:30 PM, and Dinner 6:00 PM.** Please note, food is not allowed to be taken out of cafeteria. You are not permitted to bring raw meat, canned goods or glass items into the facility. Meals from outside will not be allowed in your room but can be taken and consumed in the Cafeteria. Hot beverages are not permitted from outside. Please dress appropriately, no pajamas or see-through clothing are allowed in the cafeteria.

- **Mail is distributed on the first floor from the AWS's office (room 100) Monday** through **Saturday** from **9:30 AM – 12:45 pm** and **6:00 PM – 8:00 PM.** Mail is **not** distributed on Sundays. You can ask your case manager for more information. The mailing address is **75 Catharine Street, New York, New York 10038.** Please note: DHS staff will not sign for personal packages except for medication.

- Vocational and Recreational services are provided **Monday** through **Friday** from **2:00 PM – 5:30 PM** and **Sunday 10:00 AM – 1:00 PM** and **2:00 PM – 5:30 pm.**

- See your Case Manager for **transportation assistance Monday through Friday in room 209 during day hours of operation.** Persons with verified income are not eligible for MetroCards. See your Case Manager for the criteria, request form, and with any questions you might have.

(Turn page)

- **You have the right to request a Reasonable Accommodation or Medical Needs transfer.** If you have any medical needs that are worsened by your residence at Catherine Street, please notify your Case Manager to request a reasonable accommodation or transfer. Prior to providing an accommodation or a transfer, DHS will require you to provide documentation from your doctor. All requests are subjects to DHS administrative review and approval.

- If any issues arise while you are here, please let your Case Manager know. We strive to ensure that your needs are met. If your needs are not met you may file a grievance. Grievance forms are available through your case manager, Social Services supervisors, ASW, or DHS Police.

- Please feel free to see your Case Manager if you have any other questions or concerns while you are here.

- **All residents must leave the Dormitory area Monday thru Friday at 9:00 AM. You may return at 5:00 PM.**

- All residents are required to participate in all fire drills and evacuation. **Smoking is prohibited through the entire facility.** Intentionally setting a fire or vandalizing property or equipment in or around the shelter premises will lead to the loss of shelter (suspension and or sanction).

- Upon entering the facility all outer garments (hoodies, coats, jackets, etc.) may be searched by **DHS** Police.

Department of Homeless Services
Department of Social Services

RESIDENCIA CATHERINE STREET PARA ADULTOS

Bienvenido a la Residencia Catherine Street para Adultos

Su administrador de casos está en la sala 209. Ellos le programarán una cita para completar el trámite de registro y evaluación dentro de los 2 días posteriores a su llegada.

Su administrador de casos colaborará con usted para desarrollar una estrategia de salida del albergue. Ellos colaborarán con usted en torno a sus actividades laborales/escolares y programarán reuniones cada dos semanas para actualizar su Plan de Vida Independiente (ILP, por sus siglas en inglés). En ocasiones, se le pudiera requerir reunirse con más frecuencia.

- El **personal de supervisión** está ubicado en las salas **214** y **210**.
- El **director de operaciones** está ubicado en la sala **215**.
- El **director de albergue** está ubicado en la sala **213.**

Favor de tener en cuenta que:

- Cada persona **tiene** que firmar la entrada y salida cada vez que ingrese o salga de las instalaciones.

- Los residentes **tienen** que firmar el registro nocturno entre las **8:00 p.m.** y las **10:00 p.m.** cada noche. Los clientes que trabajen deben presentar documentación a su administrador de casos para obtener un permiso de tardanza. El incumplir del requisito de firmar el registro nocturno **todas las noches**, resultará en no poder volver entrar a las instalaciones.

- El personal de servicios sociales realiza inspecciones **semanales** de la unidad para garantizar la seguridad y limpieza de su unidad. **Favor de tener en cuenta que entraremos a su unidad, esté usted o no presente para realizar las inspecciones.** Si ingresamos y usted no está presente, se le dejará una nota para informarle.

- Las unidades serán fumigadas semanalmente. Para asegurar que las instalaciones estén libre de plagas, debe mantener su unidad limpia y libre de desorden. Eso significa que no se deben dejar recipientes de alimentos abiertos, ni basura en la unidad durante la noche. Se deben barrer y limpiar los pisos regularmente. Favor de utilizar el recipiente de basura ubicado en cada piso, el arrojar basura es inaceptable. Con su ayuda, mantendremos las instalaciones limpias.

- Usted puede traer artículos de limpieza como limpiadores y escobas de plástico, Pine Sol, Mop 'N Glo y otros desinfectantes que no contengan cloro. **No** se le permite traer ningún tipo de cloro, amoniaco o aerosol a las instalaciones.

(Voltee la página)

- La ropa de cama se cambia dos veces por semana, los **miércoles** y **jueves**, entre las **10:30 a.m.** y las **12:45 p.m.** y entre las **6:00 p.m**. y **7:00 p.m.** La ropa de cama sucia se debe entregar en la sala 100.

- Los suministros se distribuyen los **martes** y **jueves** en la sala 100 entre las **10:30 a.m.** y **12:00 p.m.** y entre las **8:00 p.m.** y las **9:30 p.m.** Los suministros consisten en papel higiénico, jabón y toallas sanitarias.

- Si tiene problemas de mantenimiento en la unidad, infórmele a su trabajador.

- Los baños son compartidos. Sin embargo, hay instalaciones designadas para mujeres en el primer y segundo piso. Se limpian varias veces al día; si encuentra un baño que necesite limpieza, infórmele al superintendente auxiliar de albergues de Welfare (ASW, por sus siglas en inglés). Con su ayuda, mantendremos las instalaciones limpias.

- La cafetería está en el primer piso. La comida se sirve de domingo a sábado de la siguiente manera: **desayuno: 7:00 - 9:00 a.m., almuerzo: 12:00 - 1:30 p.m. y la cena a las 6:00 p. m.** Favor de tener en cuenta que no se permite sacar comida de la cafetería. No se le permite traer carne cruda, productos enlatados o artículos de vidrio a las instalaciones. No se permitirá traer comida de afuera a su habitación pero sí se permite llevar y ser consumidas en la cafetería. No se permiten bebidas calientes compradas fuera de las instalaciones. Favor de vestirse apropiadamente, no se permiten pijamas ni ropa transparente en la cafetería.

- **El correo se reparte en el primer piso desde la oficina de AWS (sala 100)** de **lunes** a **sábado** entre las **9:30 a.m. y 12:45 p.m. y las 6:00 p.m. y 8:00 p.m. No** se reparte correo los domingos. Usted puede le puede preguntar a su administrador de casos para obtener más información. La dirección de correo postal es **75 Catherine Street, New York, New York 10038. Favor de** tener en cuenta: El personal del DHS no firmará para recibir paquetes personales, excepto para los medicamentos.

- Los servicios vocacionales y de recreo se ofrecen de **lunes** a **viernes** entre las **2:00 p.m. y las 5:30 p.m.** y el **domingo** entre las **10:00 a.m.** y las **1:00 p. m.** y entre las **2:00 p.m.** y las **5:30 p.m.**

- Consulte con su administrador de casos para **obtener asistencia de transporte de lunes a viernes, en la sala 209, durante las horas laborales.** Las personas con ingresos verificados no son elegibles para recibir MetroCards. Consulte a su administrador de casos para conocer los criterios, pedir el formulario de solicitud y hacer cualquier pregunta que pueda tener.

(Voltee la página)

- **Usted tiene el derecho de solicitar algún acomodamiento razonable o traslado por necesidades médicas.** Si tiene alguna necesidad médica que ha empeorado debido a su estadía en Catherine Street, notifique a su administrador de casos para solicitar acomodamiento razonable o traslado. Antes de proporcionar acomodamiento o traslado, el DHS le pedirá la documentación proporcionada por su médico. Todas las solicitudes están sujetas a la revisión y aprobación administrativa del DHS.

- Si surge algún problema mientras esté aquí, infórmeselo a su administrador de casos. Nos esforzamos para asegurarnos de que se satisfagan sus necesidades. Si no se satisfacen sus necesidades, usted puede presentar una queja. Los formularios de quejas están disponibles a través de su administrador de casos, supervisores de servicios sociales, del superintendente auxiliar de albergues de Welfare (ASW) o de la policía del DHS.

- Por favor siéntase en plena libertad de consultar a su administrador de casos, si tiene alguna otra pregunta o inquietud mientras esté aquí.

- **Todos los residentes tienen que salir del área de dormitorio, de lunes a viernes a las 9:00 a. m. Pueden regresar a las 5:00 p.m.**

- Se requiere que todos los residentes participen en todos los simulacros de incendio y evacuación. **Está prohibido fumar en las instalaciones.** Provocar un incendio de manera intencional o la destruir la propiedad privada, o el equipo dentro o en los alrededores de las instalaciones del albergue, dará lugar a la pérdida del albergue (suspensión o sanción).

- Al ingresar a las instalaciones, la policía del **DHS** podría registrar todas las prendas exteriores (sudaderas, abrigos, chaquetas, etc.).

Department of Homeless Services
Department of Social Services

Division of Adult Services

Kingsboro STAR Men's Shelter

599 Clarkson Avenue, Building #5

Brooklyn, NY 11203

CLIENT STORAGE POLICY

Clients have seven (7) days to retrieve property that has been removed from their locker, tagged and stored in the Client Storage Room.

After 7 days, the property is considered abandoned and will be discarded due to lack of storage space.

If you return to Kingsboro STAR before the 7th day, please see the Operations Unit to retrieve your property.

Department of Homeless Services
Department of Social Services

División de Servicios para Adultos

Albergue para hombres Kingsboro STAR

599 Clarkson Avenue, Building #5

Brooklyn, NY 11203

POLÍTICA DE ALMACENAJE PARA EL CLIENTE

Los clientes tienen siete (7) días para recuperar artículos personales que hayan sido retirados de su casillero y que hayan sido etiquetados y guardados en el cuarto de almacenamiento para los clientes.

Después de 7 días, dichos artículos son considerados abandonados y serán desechos debido a la falta de espacio de almacenamiento.

Si usted regresa a Kingsboro STAR antes del séptimo día, diríjase a la Unidad de Operaciones para recuperar sus artículos personales.

Department of Homeless Services
Department of Social Services

CONSTITUENT GRIEVANCE FORM

Constituents have the right to bring grievances without fear of reprisal or of being deprived.

Instructions: Constituents must complete **Section I** and submit this form, along with any supporting materials, to the Program/Facility Director or to his/her Case Manager. If the subject of this form concerns that Director or Case Manager, Constituents should submit this form to the Department of Social Services (DSS) Office of the Ombudsman, 33 Beaver Street, 20th floor, New York, NY 10004.

Any Director or Ombudsman staff, receiving a completed form must complete **Section II** and return it to the Constituent within seven (7) business days.

Section I (To be completed by the Constituent):

Name: _____

Address/Facility/Program: _____

Social Security/Case Number: _____ Telephone: _____

Signature: _____ Date: _____

Describe the Grievance (attach additional sheets and supporting documentation, as appropriate):

(Turn page)

Section II (To be completed by the Director, or Ombudsman, staff, in seven [7] days):

Name/Title: _____

Facility/Program: _____

Address: _____

Telephone: _____ Date Grievance Received: _____

Signature: _____ Date: _____

Written Explanation or Resolution of Response (attach additional sheets and supporting documentation as appropriate):

Department of Homeless Services
Department of Social Services

FORMULARIO DE QUEJAS DEL CONSTITUYENTE

Los constituyentes tienen derecho a presentar quejas sin temor a represalias ni a ser privados de albergue.

Instrucciones: Los constituyentes deben rellenar la **sección I** y enviar este formulario, junto con cualquier documento de apoyo, al director del programa/centro o a su administrador(a) de casos. Si el tema que trata este formulario tiene que ver con dicho director o administrador de casos, los constituyentes deben enviarlo a la Oficina del Ombudsman [oficina del defensor del pueblo] en el Departamento de Servicios Sociales (DSS, por sus siglas en inglés), ubicada en el 33 Beaver Street, 20th floor, New York, NY 10004.

El/la director(a) o miembro del personal de la Oficina del Ombudsman que reciba el formulario completado, debe rellenar la **sección II** y devolver el formulario al constituyente en un plazo de siete (7) días hábiles.

Sección I (a ser rellenada por el/la constituyente):

Nombre: _____

Dirección/centro/programa: _____

Número de Seguridad Social/caso: _____ Teléfono: _____

Firma: _____ Fecha: _____

Describa la queja (adjunte hojas adicionales y documentación de apoyo, según corresponda):

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

(Voltee la página)

Sección II (a ser rellenada por el/la directora(a), Ombudsman o miembro del personal, en siete [7] días hábiles):

Nombre/cargo: _____

Centro/programa: _____

Dirección: _____

Teléfono: _____ Fecha en la que se recibió la queja: _____

Firma: _____ Fecha: _____

Explicación escrita o respuesta de resolución (adjunte hojas adicionales y documentación de apoyo, según corresponda):

Department of Homeless Services
Department of Social Services

CONSTITUENT GRIEVANCE REVIEW FORM

Constituents have the right to bring grievances without fear of reprisal or of being deprived of shelter.

Instructions: Constituents must complete **Section I** and submit to the Department of Social Services (DSS) Office of the Ombudsman, 33 Beaver Street, 20th floor, New York, NY 10004. The Office of the Ombudsman, along with the appropriate Department of Homeless Services (DHS) staff, must complete and sign **Section II**, and provide a copy to the Director. A copy shall be retained with the DSS Office of the Ombudsman and placed in the client's case record.

Section I (To be completed by the Constituent):

I have reviewed the Director's response to my Constituent Grievance Form, which is dated _____.

I, _____, do not believe that the response to my grievance was satisfactory and I request a review.

_____ _____
Client Signature Date

_____
Shelter Name

Describe why the response is unsatisfactory:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

(Turn Page)

<u>Section II</u> (To be completed by the Director of the Office of the Ombudsman or function equivalent, and by the appropriate Program Administrator.)

Name/Title: _____

Facility/Program: _____

Address: _____

Telephone: _____ Date Grievance Received: _____

Signature: _____ Date: _____

Written Explanation or Resolution of Response (attach additional sheets and supporting documentation as appropriate):

Department of Homeless Services
Department of Social Services

FORMULARIO DE REVISIÓN DE QUEJAS DEL CONSTITUYENTE

Los constituyentes tienen derecho a presentar quejas sin temor a represalias ni a ser privados de albergue.

Instrucciones: Los constituyentes deben rellenar la **sección I** y enviar el formulario a la Oficina del Ombudsman [oficina del defensor del pueblo] en el Departamento de Servicios Sociales (DSS, por sus siglas en inglés), ubicada en el 33 Beaver Street, 20th floor [piso], New York, NY 10004. La Oficina del Ombudsman, junto con el personal correspondiente del Departamento de Servicios para Personas sin Vivienda (DHS, por sus siglas en inglés), deben rellenar y firmar la **sección II** y entregar una copia al director. Dicha oficina del DSS debe conservar una copia y agregarla al archivo del caso del cliente.

Sección I (a ser rellenada por el/la constituyente):

He revisado la respuesta del director a mi formulario de quejas del constituyente, con fecha de _____.

Yo, _____, no pienso que la respuesta a mi queja es satisfactoria y solicito una revisión.

_____ _____
Firma del cliente/de la clienta Fecha

_____
Nombre del albergue

Describa por qué la respuesta es insatisfactoria:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

(Voltee la página)

<u>Sección II</u> (a ser rellenada por el/la directora(a) de la Oficina del Ombudsman o persona con un cargo equivalente y por el/la administrador(a) del programa correspondiente).

Nombre/cargo: _____

Centro/programa: _____

Dirección: _____

Teléfono: _____ Fecha en la que se recibió la queja: _____

Firma: _____ Fecha: _____

Explicación escrita o respuesta de resolución (adjunte hojas adicionales y documentación de apoyo, según corresponda):

Department of Homeless Services
Department of Social Services

NOTICE OF REFERRAL TO SHELTER

Client Last Name:	Client First Name:	CARES ID:
Client Preferred Name:	Client Preferred Pronoun(s):	
Shelter Referred **To**:	Address:	
Shelter Referred **From**:	Date and Time Referred:	

☐ **NEW APPLICANT/RETURNEE APPLICANT**

The Department of Homeless Services (DHS) is referring you to the shelter named above.

- Male applicants who are new to the shelter system or have been absent more than six months from the shelter system are referred to the Men's Intake Shelter for processing and assignment to an Assessment/Triage and Referral facility.
- Female applicants who are new to the shelter system or have been absent more than six months from the shelter system are referred directly to Women's Assessment/Triage and Referral facility.

A detailed assessment process will help us learn what your current needs are. After your assessment has been completed, you will be asked to go to a shelter, which is best able to provide the services you need. You cannot transfer to any other Adult Services shelter during your Assessment/Triage and Referral facility stay without approval.

☐ **RETURNEE**

The agency is referring you to your Official Shelter for reevaluation and counseling by the same social services and clinical staff that the shelter assigned to you. It is the best way for you to get the specific services you need.

☐ **TEMPORARY ASSIGNMENT**

The agency is referring you to a Temporary Shelter tonight. You must return to your Official Shelter before 12 noon tomorrow.

TO ALL CLIENTS: You are not eligible for services at any other DHS shelter, and you many not transfer to any other shelter without agency approval.

(Turn Page)

The information in this notice has been explained to me and I understand its contents.

Client Signature _____ Date _____

FOR DHS STAFF USE ONLY

I have explained this form to the client. ☐ Client refused to sign.

Staff Name (print) _____ Staff Signature _____

Staff Title _____ Date _____

Department of Homeless Services
Department of Social Services

AVISO DE REFERENCIA AL ALBERGUE

Apellido del cliente:	Nombre del cliente:	Identificación de CARES:
Nombre que prefiere el cliente/la clienta:	Pronombres de género que prefiere el cliente/ la clienta:	
Albergue al que fue referido(a):	Dirección:	
Albergue que hace la referencia:	Fecha y hora de la referencia:	

☐ **SOLICITANTE NUEVO O QUE REGRESA**

El Departamento de Servicios para Personas sin Vivienda (DHS, por sus siglas en inglés) le está refiriendo al albergue indicado arriba.

- Los solicitantes masculinos que son nuevos en el sistema de albergues o no han estado en el sistema de albergues durante más de seis meses son referidos al centro de registro para hombres, para tramitar y asignarle a un centro de evaluación, clasificación y referencia.
- Las solicitantes que son nuevas en el sistema de albergues o no han estado en el sistema de albergues durante más de seis son referidas directamente al centro de evaluación, clasificación y referencia para mujeres.

Un proceso de evaluación detallado nos ayudará a conocer cuáles son sus necesidades actuales. Después de completar su evaluación, se le pedirá que vaya a un albergue que ofrezca los mejores servicios que usted necesita. Usted no puede transferirse sin autorización a ningún otro albergue de servicios para adultos durante su permanencia en el centro de evaluación, clasificación y referencia.

☐ **SOLICITANTE QUE REGRESA**

La agencia le está refiriendo a su albergue oficial para reevaluación y orientación por el personal de los mismos servicios sociales y el personal clínico que el albergue le asignó. Es la mejor forma para que usted obtenga los servicios específicos que necesita.

☐ **ASIGNACIÓN PROVISIONAL**

La agencia le está refiriendo a un albergue provisional esta noche. Debe regresar a su albergue oficial mañana antes de las 12 del mediodía.

PARA TODOS LOS CLIENTES: Usted no es elegible para recibir servicios en ningún otro albergue del DHS y no puede trasladarse a ningún otro albergue sin la autorización de la agencia.

(Voltee la página)

Se me ha explicado la información en este aviso y comprendo su contenido.

Firma del cliente/de la cliente

Fecha

FOR DHS STAFF USE ONLY

I have explained this form to the client. ☐ Client refused to sign.

Staff Name (print)

Staff Signature

Staff Title

Date

Department of Homeless Services
Department of Social Services

CLIENT NOTICE OF SHELTER BED ASSIGNMENT/SERVICES

Client Last Name:	Client First Name:	CARES ID:
Client Preferred Name:	Client Preferred Pronoun(s):	

I understand that I have been offered a bed at _____ Shelter.

☐ I accept the above bed assignment/services and I understand that I must accept transportation at the time provided.

_____
Client Signature

☐ I do **not** accept the above bed assignment/ services. I understand that by refusing to accept the bed assignment, I may be asked to leave this facility.

_____
Client Signature

FOR DHS STAFF USE ONLY – TWO SIGNATURES REQUIRED

I have explained this form to the client. ☐ Client refused to sign.

Staff Name (print)	Staff Signature
Staff Title	Date
Supervisor Name (print)	Supervisor Signature
Supervisor Title	Date

(Turn Page)

FOR DHS STAFF USE ONLY

Comments: _____

Stamp Dates and Times Below:

TRIAGE	SCREENING	TRANSPORT	REFUSAL	SCIMS/ANCHOR UPDATE

Department of Homeless Services
Department of Social Services

AVISO AL CLIENTE SOBRE SERVICIOS Y ASIGNACIÓN DE CAMA EN ALBERGUE

Apellido del cliente/de la clienta:	Nombre del cliente/de la clienta:	Identificación de CARES:
Nombre que prefiere el cliente/la clienta:	Pronombres de género que prefiere el cliente/ la cliente:	

Comprendo que se me ha ofrecido una cama en el albergue _____.

☐ Acepto los servicios y la asignación de cama indicados arriba y comprendo que tengo que aceptar el transporte a la hora proporcionada.

_____
Firma del cliente

☐ **No** acepto los servicios ni la asignación de cama indicados arriba. Comprendo que si me niego a aceptar la asignación de cama, se me podría pedi que salga de este centro.

_____
Firma del cliente

FOR DHS STAFF USE ONLY – TWO SIGNATURES REQUIRED

I have explained this form to the client. ☐ Client refused to sign.

Staff Name (print)	Staff Signature
Staff Title	Date
Supervisor Name (print)	Supervisor Signature
Supervisor Title	Date

(Voltee la página)

FOR DHS STAFF USE ONLY

Comments: _____

Stamp Dates and Times Below:

TRIAGE	SCREENING	TRANSPORT	REFUSAL	SCIMS/ANCHOR UPDATE

Department of Homeless Services
Department of Social Services

Single Adult Safe Permanent Housing Referral Notice

The Department of Homeless Services (DHS) wants you to have a safe living environment when you exit shelter for permanent housing in New York City.

While you can choose to live where you want when you leave your program, we have created guidelines about the housing options you can be referred to by your Single Adult Provider. If you choose a housing option on your own that fails to meet these guidelines, it is possible that provider staff will not recommend it.

Provider staff cannot refer you to housing that:

- Has an active vacate order from NYC Department of Building (DOB), NYC Department of Housing Preservation and Development (HPD) and/or the Fire Department;
- Is owned by a landlord being sued by NYC HPD concerning the property;
- Has one or more Hazard Class I violations (the most serious violation type) on NYC HPD's "Complaint, Violations, and Registration Information" database;
- Is enrolled in HPD's Alternative Enforcement Program;
- Has one or more complaint about overcrowding or illegal use posted on the NYC DOB website within four years before the time your exit is planned, indicating either:
  - a violation or summons was served; or
  - the complaints could not be resolved because the owner did not let inspectors in; or
  - the complaint was never addressed;
- Appears on the New York States Department of Health's Referral Suspension List or Uncertified Facilities lists.

If you believe a housing option is unsafe, you should call 311 or visit them at www.nyc.gov/311 . Let a provider staff know if you need help reporting unsafe housing.

(Turn Page)

CLIENT:

I have read and have had this form explained to me. I understand that I may choose where I want to live when I leave the program, but this choice may not be recommended by the provider staff if it fails to meet guidelines.

_____	_____	_____
Print Name	Signature	Date

Staff

I have explained this form to the client.

_____	_____	_____
Print Name	Signature	Date

Department of Homeless Services
Department of Social Services

Aviso de Referencia para Vivienda Permanente y Segura para Adultos Solteros

El Departamento de Servicios para Personas sin Vivienda (DHS, por sus siglas en inglés) desea que usted viva en un entorno seguro cuando salga del albergue hacia una vivienda permanente en la ciudad de Nueva York.

Si bien usted puede elegir dónde desea vivir cuando salga del programa, nosotros hemos creado directrices sobre las opciones de vivienda para las cuales usted puede ser referido(a) por el proveedor de albergue para adultos solteros. Si usted elige una vivienda por cuenta propia, que no cumpla con estas directrices, es posible que el personal del proveedor no la recomiende.

El personal del proveedor no puede referirle a una vivienda que:

- tenga una orden de desocupar pendiente, expedida por el Departamento de Edificios de NYC (NYC DOB, por sus siglas en inglés), por el Departamento de Desarrollo y Preservación de la Vivienda de NYC (NYC HPD, por sus siglas en inglés) y/o por el Cuerpo de Bomberos de NYC (FDNY, por sus siglas en inglés);
- sea propiedad de un dueño(a) que esté siendo demandado(a) por el NYC HPD, debido a la propiedad;
- tenga una o más violaciones peligrosas clase I (el tipo de violación más grave) en la base de datos de información de registro, violaciones y quejas del NYC HPD;
- esté inscrita en el Programa de Cumplimiento Alternativo del NYC HPD;
- tenga una o más quejas por aglomeración o uso ilícito publicadas en el sitio web del NYC DOB durante los cuatro años anteriores a su salida planificada, que indique alguna de estas situaciones:
  - entrega de alguna violación o multa o;
  - las quejas no fueron resueltas debido a que el dueño(a) no le permitió la entrada a los inspectores o;
  - la queja nunca fue encarada;
- esté nombrada en la lista de instalaciones no certificadas o en la lista de suspensión de referencia del Departamento de Salud del Estado de Nueva York.

Si piensa que la opción de vivienda es insegura, usted debe llamar al 311 o entrar a la página www.nyc.gov/311. Infórmele al personal del proveedor si necesita ayuda para reportar la vivienda insegura.

(Voltee la página)

PARA EL CLIENTE/LA CLIENTA:

He leído y se me ha explicado este documento. Comprendo que puedo elegir dónde deseo vivir cuando salga del programa, pero puede que esta opción no sea recomendada por el personal del proveedor si no cumple las condiciones de las directrices.

_____	_____	_____
Nombre en letra de molde	Firma	Fecha

Para el personal:

Le he explicado este documento al cliente/la clienta.

_____	_____	_____
Nombre en letra de molde	Firma	Fecha

Department of Homeless Services
Department of Social Services

Single Adult Permanent Placement Referral Instructions

Providers must check that **ALL** available housing options and placements meet the Department of Homeless Services (DHS) guidelines against substandard and unsafe violations as set forth below on ALL four (4) NYC Agency websites:

1. **NYC Department of Building (DOB) Guidelines (www.nyc.gov/buildings)**
   Placement meets DHS guidelines if:
   a. There is no active vacate order from the NYC DOB – due to the building being damaged, illegal or unsafe – regardless of whether the vacate order is partial or full, and regardless of whether only one (1) unit in the building/house is vacated and this is not the unit where your client is being placed; and
   b. No active complaint in the four (4) years prior to the move-out date in:
      1) Complaints or problems reported to the NYC DOB –in the following three (3) areas:
         a) **31** – Certificate of Occupancy – None/ Illegal/Contrary to Certificate of Occupancy
         b) **45** – Illegal Conversion
         c) **71** – Single Room Occupancy (SRO) – Illegal work/ No permit/ Change in Occupancy – Use
      2) Disposition codes – that were dismissed, referred elsewhere, if inspectors were unable to gain access, etc.:
         a) **A** means a violation was served
         b) **C** means that the inspectors were unable to gain access to inspect.

2. **NYC Department of Housing Preservation and Development (HPD) Guidelines (www.nyc.gov/hpd)**
   Placement meets DHS guidelines if:
   a. There is no vacate order for any unit in the building, either partial or full
   b. The NYC HPD is not currently in litigation against the owner of the building
   c. The building is not part of the NYC HPD's Alternative Enforcement Program.

(Turn page)

3. **NYC Fire Department (FDNY) Guidelines (www.nyc.gov/fdny)**
   Placements meets DHS guidelines if:
   The FDNY has not issued a vacate order for this building, full or partial.

4. **New York State Department of Health (NYS DOH) Guidelines (www.health.state.ny.us)**
   Placement meets DHS guidelines if:
   Address is not found on the Referral Suspension or Uncertified Facilities lists.

Department of Homeless Services
Department of Social Services

Instrucciones para Referencia de Colocación Permanente para Adultos Solteros

Los proveedores **tienen** que verificar que **TODAS** las opciones de vivienda y que las colocaciones cumplan las directrices del Departamento de Servicios para Personas sin Vivienda (DHS, por sus siglas en inglés) contra la infravivienda y las violaciones por condiciones peligrosas, como se establece en los cuatro (4) sitios web de la Agencia de NYC:

1. **Directrices del Departamento de Edificios de NYC (NYC DOB, por sus siglas en inglés) (www.nyc.gov/buildings)**
   La colocación cumple con las directrices del DHS si:
   a. No existen órdenes de desocupar pendientes, expedidas por el NYC DOB – a causa de que el edificio esté deteriorado, sea ilegal o inseguro – sin importar que la orden de desocupar sea parcial o determinante, y aún así solo haya un (1) solo apartamento desocupado en el edificio/vivienda y no sea el apartamento donde se colocará al cliente/la clienta y;
   b. No existen quejas pendientes durante los cuatro (4) años anteriores a la fecha de salida:
      1) Quejas o problemas reportados al NYC DOB – en las tres (3) siguientes áreas:
         a) **31** – Cédula de habitabilidad (Certificate of Occupancy) – ninguna/ilegal/uso contrario a la cédula de habitabilidad
         b) **45** – Conversión ilegal
         c) **71** – Habitación para ocupación individual (SRO, por sus siglas en inglés) – trabajo ilegal/sin permiso/cambio en el tipo ocupación – en el uso
      2) Códigos de disposición – que fueron desestimados, referidos a otro lugar, si los inspectores no pudieron tener acceso, etc.:
         a) Código **A** significa que se notificó sobre una violación.
         b) Código **C** significa que los inspectores no pudieron tener acceso para inspeccionar.

2. **Directrices del Departamento para el Desarrollo y Preservación de la Vivienda de NYC (NYC HPD, por sus siglas en inglés) (www.nyc.gov/hpd)**
   La colocación cumple con las directrices del DHS si:
   a. No existe ninguna orden de desocupar ninguno de los apartamentos en el edificio, ni parcial ni determinante.
   b. El NYC HPD no tiene ningún litigio pendiente contra el dueño(a) del edificio.
   c. El edificio no forma parte del Programa de Cumplimiento Alternativo de NYC HPD.

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3. **Directrices del Cuerpo de Bomberos de NYC (FDNY, por sus siglas en inglés) (www.nyc.gov/fdny)**
   La colocación cumple con las directrices del DHS si:
   El FDNY no ha expedido una orden de desocupar ese edificio, ni determinante ni parcial.

4. **Directrices del Departamento de Salud del Estado de Nueva York (NYS DOH, por sus siglas en inglés) (www.health.state.ny.us)**
   La colocación cumple con las directrices del DHS si:
   La dirección no aparece en la lista de suspensión de referencias o en la lista de instalaciones no certificadas.

Department of Homeless Services
Department of Social Services

Letter to Acknowledge Apartment Selected Does Not Meet The Department of Homeless Services Housing Referral Criteria

I have been advised by my caseworker that the apartment I selected at:

_____,

(Address)

does not meet the Department of Homeless Services' Single Adult Permanent Housing Referral Criteria because of:

_____.

(Violation)

Having been advised, I understand that I may still choose to exit shelter to this address, and I may contact the Department of Buildings for more information about this property through 311.

_____ _____
Client Signature Date

_____ _____
Case Worker / Housing Specialist Name (Print) Date

_____
Shelter Name

Department of Homeless Services
Department of Social Services

Carta para Reconocer que el Apartamento Seleccionado Incumple el Criterio de Referencia del Departamento de Servicios para Personas sin Vivienda

He sido informado(a) por mi trabajador(a) de casos que el apartamento que yo seleccioné en el:

_____,

(Dirección)

no cumple con los criterios de referencia para vivienda permanente de adultos solteros del Departamento de Servicios para Personas sin Vivienda, debido a:

_____.

(Violación)

Una vez informado(a), comprendo que aún podría elegir salir del albergue hacia esa dirección y podría contactar al Departamento de Edificios para obtener más información sobre esa propiedad llamando al 311.

_____ _____
Firma del cliente/de la clienta Fecha

_____ _____
Trabajador(a) de casos/Especialista en vivienda Fecha

_____
Nombre del albergue

Department of Homeless Services
Department of Social Services

DHS-41 (E) 06/26/2019

CARES Client Confidentiality and the Data Protection Policy Acknowledgement Form (Dual Roles DHS Staff)

I, _____, acknowledge that I have received, read, and understood DHS Procedure No. 12-001: CARES Client Confidentiality and Data Protection Policy (the "Policy"). I understand that the Policy applies discretely to both my primary and secondary role (or overtime role), and I agree to comply with the requirements contained in the Policy with respect to both. I further understand that I am only authorized to utilize the information and access afforded each role expressly for the commission of the responsibilities of that role. Finally, I understand that failure to comply with the Policy may result in disciplinary and other adverse employment actions, up to and including termination of my employment, and civil and criminal penalties.

CARES USER

_____ _____
Signature Date

_____
Division

_____
Email Address

WITNESS

_____ _____
Signature Date

_____
Printed Name

This form must be submitted with the Access Request Form (ARF) to CARESARF@dhs.nyc.gov

Department of Homeless Services
Department of Social Services

DHS-41a (E) 06/26/2019

CARES Client Confidentiality and the Data Protection Policy Acknowledgement Form (DHS Staff)

I, _____, acknowledge that I have received, read, and understood DHS Procedure No. 12-001: CARES Client Confidentiality and Data Protection Policy (the "Policy"). I understand and agree to comply with the requirements contained in the Policy. I further understand that failure to comply with the Policy may result in disciplinary and other adverse employment actions, up to and including termination of my employment, and civil and criminal penalties.

CARES USER

_____ _____
Signature Date

_____
Division

_____
Email Address

WITNESS

_____ _____
Signature Date

_____
Printed Name

This form must be submitted with the Access Request Form (ARF) to CARESARF@dhs.nyc.gov

Department of Homeless Services
Department of Social Services

CARES Client Confidentiality and the Data Protection Policy Acknowledgement Form (Provider)

I, _____, acknowledge that I have received, read, and understood DHS Procedure No. 12-001: CARES Client Confidentiality and Data Protection Policy (the "Policy"). I understand and agree to comply with the requirements contained in the Policy. I further understand that failure to comply with the Policy may result in disciplinary and other adverse employment actions, up to and including termination of my employment, and civil and criminal penalties.

CARES USER

_____ _____
Signature Date

_____
Provider Name

WITNESS

_____ _____
Signature Date

_____
Printed Name

Unique Identifier: DHS needs to collect a unique identifier for each CARES provider user for identification purposes when calling for a password reset. When a user calls the help desk to request a password reset, they will be asked for their verification PIN. Please select a four digit number you will remember. If you forget your password and verification PIN, the help desk will not be able to automatically reset your password.

Please enter your verification PIN here: ___ /___ /___ /___

Human Resources Administration
Department of Homeless Services
Department of Social Services

Client Name: _____

Date: _____

Letter Number: _____

Expiration Date: _____

Rental Assistance Supplement: Potential Eligibility Letter

_____ may be eligible to rent an apartment for up to $_____ per month with CityFHEPS. The family must find a qualifying apartment and receive final approval to receive the rental assistance supplement.

Landlords will receive the full first month's rent and the next three (3) or eleven (11) months of the rental assistance supplement when the family is approved. Currently, landlords may get a $_____ lease-signing bonus.

Landlords may also be eligible for a number of additional incentives. For more information on landlord incentives, visit www.nyc.gov/dsshousing.

Licensed brokers may receive a fee of up to 15% of the annual rent. The 15% broker's fee is available for packets submitted by _____.

Refusal to accept CityFHEPS may constitute source of income discrimination under the NYC Human Rights Law Sec. 8-107(5)(a)(1)-(2) and/or (c)(1)-(3).

See **page 2** for required documents and further information.

(Turn Page)

Landlords must give the family the following completed documents:

1. Signed lease or written agreement to rent the apartment to the family for at least one year
2. Request for security
3. Landlord's **W-9** (needed to receive all payments)
4. Unit Hold Incentive Voucher (**HRA-145**), if requested
5. Payee form if the landlord makes someone his/her payee
6. Landlord Information Form
7. Proof of ownership

Brokers who request a broker's fee must also give the family these completed documents:

1. Broker's Request for Enhanced Fee Payment by Check **(HRA-121)**
2. Copy of the broker's current license

Please visit www.nyc.gov/dsshousing to download our forms mentioned in the tables above and for more information about CityFHEPS.

If you have any questions, please contact _____.
(Contact name and number)

CityFHEPS is similar to the federal Section 8 program in that, subject to the availability of funding, it provides assistance, including rental assistance of specified amounts, to landlords and tenants who want to form a landlord–tenant relationship. Any contractual relationship will be solely between each tenant participating in the program and each tenant's landlord participating in the program.

Human Resources Administration
Department of Homeless Services
Department of Social Services

Nombre del cliente: _____

Fecha de vencimiento: _____

Fecha: _____

Número de carta: _____

Suplemento de Asistencia de Alquiler: Carta de Posible Elegibilidad

_____ podría ser elegible para alquilar un apartamento de hasta $_____ mensuales, mediante CityFHEPS. La familia debe encontrar un apartamento que califique y recibir aprobación final para recibir el suplemento de asistencia de alquiler.

Los arrendadores recibirán el primer mes de alquiler completo y tres (3) u once (11) meses del suplemento de asistencia de alquiler, cuando la familia sea aprobada. En la actualidad, los arrendadores podrían recibir un bono de $_____ por firmar el contrato.

Los arrendadores también podrían ser elegibles para un número de incentivos adicionales. Para obtener más información sobre los incentivos del arrendador, entre a www.nyc.gov/dsshousing.

Los agentes inmobiliarios con licencia podrían recibir un porcentaje de comisión de hasta 15% del alquiler anual. El 15% de comisión del agente inmobiliario está disponible para los paquetes presentados de aquí al _____.

El rehusarse aceptar CityFHEPS podría constituir discriminación en base a la fuente de ingreso conforme a la Ley de Derechos Humanos de la ciudad de Nueva York, Sección 8-107(5)(a)(1)-(2) y/o (c)(1)-(3).

Consulte la **página 2** para ver los documentos requeridos y más información.

(Voltee la página)

Loa arrendadores deben entregarle a la familia los siguientes documentos rellenados:

1. Contrato de alquiler firmado o acuerdo de alquiler escrito para alquilarle el apartamento a la familia durante por lo menos un año.
2. Petición del depósito de garantía.
3. Formulario **W-9** del arrendador (necesario para recibir todos los pagos)
4. Vale de incentivo para reservar la unidad (**HRA-145 Unit Hold Incentive Voucher**), si se solicita.
5. Formulario de beneficiario (Payee form) si el arrendador nombra a un beneficiario.
6. Formulario de Información del Arrendador (Landlord Information Form).
7. Comprobante de propiedad (Proof of Ownership).

Los agentes inmobiliarios que soliciten comisión también deben entregarle a la familia los siguientes documentos rellenados:

1. Petición del agente inmobiliario para recibir pago de comisión aumentada por cheque **(HRA-121 Broker's Request for Enhanced Fee Payment by Check)**
2. Copia de licencia actual del agente inmobiliario.

Favor de entrar a www.nyc.gov/dsshousing para descargar los formularios mencionados en la casilla anterior o si le gustaría obtener más información sobre CityFHEPS.

Si tiene cualquier pregunta, favor de contactar a _____.
(Nombre y número de contacto)

CityFHEPS es similar al programa Federal de la Sección 8 en el sentido de que, sujeto a la disponibilidad de fondos, provee asistencia, incluida asistencia de alquiler en determinadas cantidades, a los arrendadores e inquilinos que deseen establecer una relación mutua. Toda relación contractual se establecerá exclusivamente entre cada inquilino participante en el programa y el arrendador del inquilino que también participe en el programa.

Human Resources Administration
Department of Homeless Services
Department of Social Services

Client Name: _____

Date: _____

Letter Number: _____

Expiration Date: _____

Potential Eligibility for a Rental Assistance Supplement

_____ may be eligible for CityFHEPS. CityFHEPS helps eligible households rent and keep their housing. The household must find a qualifying apartment, Single Room Occupancy (SRO) unit, or room and receive final approval to receive the rental assistance supplement.

The maximum allowable monthly rent for each housing unit type is listed below:

- Apartment: $_____ for this household.
- Room: $800 (only available for households of one (1) or two (2) adults).
- Single room occupancy unit: $1,047 (only available for a single adult).

Landlords will receive the full first month's rent and the next three (3) or eleven (11) months of the rental assistance supplement when the household is approved. Currently, landlords who rent an apartment may get a $_____ lease-signing bonus.

Landlords may also be eligible for a number of additional incentives. For more information on landlord incentives, visit www.nyc.gov/dsshousing.

Licensed brokers may receive a fee of up to 15% of the annual rent. The 15% broker's fee is available for packets submitted by _____.

Refusal to accept CityFHEPS may constitute source of income discrimination under the NYC Human Rights Law Sec.8-107(5)(a)(1)-(2) and/or (c)(1)-(3).

See **page 2** for required documents.

(Turn Page)

Landlords must give the household the following completed documents:

1. Signed lease or written agreement to rent the apartment, room, or SRO to the household for at least one year
2. Request for security
3. Landlord's **W-9** (needed to receive all payments)
4. Unit Hold Incentive Voucher (**HRA-145**), if requested
5. Payee form if the landlord makes someone his/her payee
6. Room Allocation form (if applicable)
7. Landlord Information Form
8. Proof of ownership

Brokers who request a broker's fee must also give the household these completed documents:

1. Broker's Request for Enhanced Fee Payment by Check **(HRA-121)**
2. Copy of the broker's current license

Please visit www.nyc.gov/dsshousing to download our forms mentioned in the tables above and for more information about CityFHEPS.

If you have any questions, please contact _____.
(Contact name and number)

CityFHEPS is similar to the federal Section 8 program in that, subject to the availability of funding, it provides assistance, including rental assistance of specified amounts, to landlords and tenants who want to form a landlord–tenant relationship. Any contractual relationship will be solely between each tenant participating in the program and each tenant's landlord participating in the program.

Human Resources Administration
Department of Homeless Services
Department of Social Services

Nombre del cliente: _____

Fecha: _____

Fecha de vencimiento: _____

Número de carta: _____

Posible Elegibilidad para el Suplemento de Asistencia de Alquiler

_____ podría ser elegible para CityFHEPS. CityFHEPS ayuda a los hogares elegibles a alquilar y a conservar sus viviendas. El hogar debe encontrar un apartamento, una habitación de ocupación individual (SRO, por sus siglas en inglés) o una habitación normal que califique y recibir aprobación final para recibir el suplemento de asistencia de alquiler.

El máximo de alquiler mensual permitido por cada tipo de unidad se lista a continuación:

- Apartamento: $_____ para este hogar.
- Habitación normal: $800 (solo disponibles para hogares de uno (1) o dos (2) adultos).
- Unidad de habitación de ocupación individual: $1,047 (solo disponible para un solo adulto).

Los arrendadores recibirán el primer mes de alquiler completo y tres (3) u once (11) meses del suplemento de asistencia de alquiler, cuando el hogar sea aprobado para cualquier tipo de unidad de vivienda. En la actualidad, los arrendadores podrían recibir un bono de $_____ por firmar el contrato.

Los arrendadores también podrían ser elegibles para un número de incentivos adicionales. Para obtener más información sobre los incentivos del arrendador, entre a www.nyc.gov/dsshousing.

Los agentes inmobiliarios con licencia podrían recibir un porcentaje de comisión de hasta 15% del alquiler anual. El 15% de comisión del agente inmobiliario está disponible para los paquetes presentados de aquí al _____.

El rehusarse aceptar CityFHEPS podría constituir discriminación en base a la fuente de ingreso, conforme a la Ley de Derechos Humanos de la ciudad de Nueva York, Sección 8-107(5)(a)(1)-(2) y/o (c)(1)-(3).

Consulte la **página 2** para ver los documentos requeridos y más información.

(Voltee la página)

Loa arrendadores deben entregarle a la familia los siguientes documentos rellenados:

1. Contrato de alquiler firmado o acuerdo de alquiler escrito para alquilarle el apartamento a la familia durante por lo menos un año.
2. Petición de depósito de garantía.
3. Formulario **W-9** del arrendador (necesario para poder recibir todos los pagos)
4. Vale de incentivo para reservar la unidad (**HRA-145 Unit Hold Incentive Voucher**), si se solicita.
5. Formulario de beneficiario (Payee form), si el arrendador nombra a un beneficiario.
6. Formulario de asignación de habitación (si corresponde).
7. Formulario de información para el arrendador (Landlord Information Form).
8. Comprobante de propiedad.

Los agentes inmobiliarios que soliciten comisión también deben entregarle a la familia los siguientes documentos rellenados:

1. Petición del agente inmobiliario para recibir pago de comisión aumentada por cheque **(HRA-121 Broker's Request for Enhanced Fee Payment by Check)**
2. Copia de licencia actual del agente inmobiliario.

Favor de entrar a www.nyc.gov/dsshousing para descargar los formularios mencionados en la casilla anterior o si le gustaría obtener más información sobre CityFHEPS.

Si tiene cualquier pregunta, favor de contactar a _____.
(Nombre y número de contacto)

CityFHEPS es similar al programa Federal de la Sección 8 en el sentido de que, sujeto a la disponibilidad de fondos, provee asistencia, incluida la asistencia de alquiler en determinadas cantidades, a los arrendadores e inquilinos que deseen establecer una relación mutua. Toda relación contractual se establecerá exclusivamente entre cada inquilino participante en el programa y el arrendador del inquilino que también participe en el programa.