Department of Homeless Services
Department of Social Services

OFFICE OF POLICY, PROCEDURES AND TRAINING

DHS-PB-2023-007

Policy Subject:	**Applicable To:**	**Effective Date:**
Referrals of Runaway Homeless Youth to Department of Homeless Services Shelters	All DHS Intake Centers	May 25, 2023 *(Replaces DHS-PB-2017-05)*

ADMINISTERED BY:	**APPROVED BY:**
Division of Adult Services Division of Family Services Housing Emergency Referral Operations	Joslyn Carter, Administrator Department of Social Services/ Department of Homeless Services

■ INTRODUCTION

Runaway and Homeless Youth ("RHY") services are funded by the Department of Youth and Community Development (DYCD) and run by DYCD-funded RHY service providers. Runaway and homeless youth and young adults ("youth") may need shelter services beyond the State-allowed length of stay in a DYCD-funded shelter; others may need support beyond the maximum age a person can receive DYCD-funded shelter services. To meet their ongoing needs, DYCD refers these youth to the Department of Homeless Services (DHS).

Definitions for DYCD Clients[1]

1. **Runaway Youth** - a person under age 18 who is absent from their legal residence without the consent of a parent, legal guardian, or custodian.
2. **Homeless Youth** - a person under age 18 who needs services and is without a place of shelter where supervision and care are available or a person who is under age 21 but is at least 18, needs services, and is without a place of shelter.
3. **Homeless Young Adult** - a person who is under age 24 but is at least age 21 who needs services and is without a place of shelter.

[1] *See* Executive Law § 532-a.

■ POLICY

It is DHS's policy that RHY service providers may refer youth who are no longer eligible for DYCD-funded shelter services to DHS shelter for service continuity. This policy applies to DYCD-funded drop-in centers, crisis shelters, and transitional independent living shelters for RHY ("RHY shelters").

■ BACKGROUND

This procedure explains the process to refer runaway homeless youth and young adults—who may be **single adults, adult couples, siblings, or youth with children**—from RHY shelters to DHS shelters. This process enables youth and young families with a DYCD shelter history to bypass DHS intake and be placed at a DHS shelter.

■ AGENCY REQUIREMENTS

To make the transition from RHY shelter to DHS shelter as seamless as possible, the following steps are necessary:

A. RHY Provider Responsibilities

1. During discharge planning, RHY providers will identify youth who meet the following criteria:

    a. youth aging out of the RHY system;
    b. youth reaching their maximum allowable stay in RHY shelter in the next 30 days; and
    c. youth designated by DYCD.

    RHY providers will find out which of these youth would like to move to DHS shelter.

2. Youth interested in DHS shelter must sign consent to release confidential medical, mental health, and substance use disorder information so records may be shared with DHS/shelter staff. This consent will allow DHS to get the information needed for appropriate placement and removes the barrier of having to go to DHS intake for screening, evaluation, and shelter referral.

3. RHY providers will send a completed **DYCD to DHS Shelter Referral Worksheet** ("Shelter Referral Worksheet") (**DHS-4**) to DHS at least 20 business days before the youth's or family's expected transfer date.

    a. For single adults and adult families, email the Shelter Referral Worksheet to dycdreferral@dhs.nyc.gov.

    b. For families with children (i.e., family includes a pregnant person or a child under 18), email the Shelter Referral Worksheet to dycdfamilyreferral@dhs.nyc.gov.

4. The RHY provider will advise the DHS intake liaison through the e-mailbox of any needs that may affect the youth's or family's placement.

5. Every Friday, DYCD's Vulnerable and Special Needs Youth Division will send a decrypted electronic alert to the appropriate DHS intake liaison e-mailbox. The alert includes the names, dates of birth, and case composition for each case referred the week before.

   Note: For referrals of related youth, such as siblings, the Shelter Referral Worksheet must note the familial relationship. In the case of siblings, if one of the siblings is a minor, the older sibling must be the legal guardian for them to be placed together.

B. DHS Responsibilities

1. DHS intake liaisons will create a Client Assistance and Rehousing Enterprise System (CARES) Temporary Housing Application (THA) file for each youth or family by adding information from the RHY provider to the THA and uploading supporting documentation to the CARES document repository. DHS will find space at a suitable DHS shelter.

2. The DHS intake liaison will:

   a. Contact the RHY provider to coordinate the youth's expected arrival at the DHS shelter,

   b. Ensure the bed/unit is appropriate for the youth or family, and

   c. Inform the RHY provider and DHS program of the shelter location

3. If there are medical concerns, the intake liaison will consult with the DHS medical director (*see* Guidelines for Addressing Clinical Needs and Request for Consultation from the DHS Office of the Medical Director, DHS-PB-2018-005). If a youth has a disability and needs a reasonable accommodation (RA), the intake liaison will email the Disability & Functional Needs (DAFN) unit at DAFNRARequests@dhs.nyc.gov and copy the Office of Disability Affairs (ODA) at DisabilityAffairs@dss.nyc.gov for an assessment.

   The intake liaison must enter all RA requests into the Reasonable Accommodations Management System (RAMS) using a "Reasonable Accommodation Request Form" (**DHS-13**). See *DHS Interim Reasonable Accommodation Request Process* (DHS-PB-2022-002) for instructions.

4. The DHS intake liaison will email the relevant DHS intake center, Housing Emergency Referral Operations (HERO) for families with children and adult families or Intake Vacancy Control (IVC) for single adults, noting the placement need. The DHS intake liaison will ask the DYCD contact any follow-up questions.

5. HERO/IVC will inform the assigned DHS shelter of the youth's or family's pending arrival and instruct the shelter to accept them.

6. All referrals to DHS shelters under this process will happen during normal business hours (Monday - Friday, 9:00 am - 5:00 pm). RHY providers will give a MetroCard to any youth transitioning to a DHS shelter. DHS shelter beds will be held for 24 hours.

7. **Families with children or adult families** who do not arrive at the DHS shelter within 24 hours of the referral will be directed to the appropriate DHS intake site for shelter assignment.

8. **Single adults** who do not arrive at the DHS shelter within 24 hours of the referral will lose their bed. They may still report to the DHS shelter for a bed assignment if one is available. If a bed is unavailable, they will be referred to another DHS shelter with an available bed and transported there.

C. Ineligible Youth
   1. Youth unwilling to consent or share the information DHS needs will be ineligible for this streamlined referral process; but those youth may always access services through the usual DHS intake process.

   2. For youth not aging out of DYCD services or designated by DYCD for referral to DHS, staff will direct them to the appropriate DHS intake site:

      a. Clients Who Identify as Men:
         30th Street Men's Intake
         400 East 30 Street
         New York, NY 10016

         OR

         HELP Men's Intake Center
         116 Williams Avenue
         Brooklyn, NY 11207

      b. Clients Who Identify as Women:
         Franklin Women's Shelter
         1122 Franklin Avenue
         Bronx, NY 10456

      c. Clients Who Identify as Transgender, Gender Non-conforming, Non-binary, or Intersex:
         The intake site where they will feel most comfortable.

Effective Immediately

■ ATTACHMENTS:

DHS-4	DYCD to DHS Shelter Referral Worksheet
DHS-13	Reasonable Accommodation Request Form
DHS-14f	Request for Consultation and Intervention from the DHS Office of the Medical Director

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DYCD TO DHS SHELTER REFERRAL WORKSHEET

asterisk (*) are required fields. If fields don't apply, select N/A

*Last Name	*First	MI	*Date

Client Registration

*Head of Household SSN, If Applicable	*Date of Birth	*Age	PA#
*Is Client Pregnant?	*Language		Family Composition

*What is your primary race?	*What is your gender?

*Client must provide a copy of identification from drop list

Emergency Contact Name/Relationship	Emergency Contact Telephone #

Other Adults (Name, DOB, SSN, Relationship)

Children (Name, DOB, SSN, Borough of School)

*Prior Residence Type	*What was your approximate length of stay at prior address

Reason for Homelessness

Primary Reason for Homelessness:	Eviction Type

City (from where client moved)	State (from where client moved)	Country (from where client moved)

Additional Homelessness Comments

Substance Abuse

Do you have a history of alcohol or drug abuse?	Are you currently receiving, or have ever, been to alcohol or drug treatment before?

Do you think your alcohol or drug abuse has contributed to your current difficulties?

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DYCD TO DHS SHELTER REFERRAL WORKSHEET

asterisk (*) are required fields. If fields don't apply, select N/A

*Last Name	*First	MI	*Date

VETERANS INFORMATION (if applicable)

Are you a military veteran (**If YES, proceed to the following veteran questions**?)

Which Military Branch did serve in	Which service era did you serve in
Date entered service	Date exited service
Do you currently receive veteran's benefits	If so, are they service connected

HEALTH SCREENING (If psycho social completed, skip this section)

Are you feeling sick right now?	Have you been discharged from a hospital or had surgery within the last month?

Have you ever had chicken pox or shingles

Do you have a contagious condition right now, such as chicken pox, pink eye, or symptoms such as fever or severe sore Throat?

Have you been released from a NYC jail within the last month?

***PLACEMENT DETAILS**

* Do you use any assistive devices	Do you have a visual or hearing impairment?
*Do you require portable oxygen?	*Do you require medical equipment?
*Do you need to refrigerate medication?	*Do you need help taking medication?

***SPECIAL CONDITIONS**

*Do you have a current diagnosis of a serious mental illness, such as schizophrenia or bipolar disorder?

*Do you have a serious developmental disability or autism?	*Do you have a current substance use problem?

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DYCD TO DHS SHELTER REFERRAL WORKSHEET

asterisk (*) are required fields. If fields don't apply, select N/A

*Last Name	*First	MI	*Date

DOMESTIC VIOLENCE (if applicable)

Does anyone in your current household or an earlier household, or your family, or your partner or ex-partner isolate you from friends and family and control what you can do and who you can see

Has anyone in your current household or an earlier household, or your family, or your partner or ex-partner ever physically hurt you or your children by, for example, pushing, kicking, hitting, slapping, choking, punching or sexually assaulting you?

Is anyone currently stalking you or your children by following you, checking up on you, harassing you, or making unwanted phone calls or text messages

Does anyone in your current household or an earlier household, or your family, or your partner or ex-partner threaten you or make you or your children feel scared or unsafe at home

Has domestic violence contributed to your current housing crisis

Have you ever entered a domestic violence shelter?

Have you ever been involved in a domestic violence situation?

DIVERSION ADDRESS DETAILS

Street #	City	Zip

ADDITIONAL DIVERSION DETAILS

Have you lost any public assistance, housing subsidies, or benefits in the last year?	Have you ever had an apartment lease or mortgage in your name?
Have you ever had to appear in housing court within the last year?	Have you ever had section 8, but lost it for any reason?
Have you ever been evicted from a NYCHA apartment?	

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DYCD TO DHS SHELTER REFERRAL WORKSHEET

asterisk (*) are required fields. If fields don't apply, select N/A

*Last Name	*First	MI	*Date

Employment

Employment From	Employer Name/Address

If you are currently employed, what is your Employment Type/Occupation?

Frequency (of pay):	Wages:

Income/Wages/Benefits

What income type(s) are you currently receiving?

Start Date/Amount?

Psychosocial Assessment

Paragraph 1: Appearance

Include information on: usual appearance including physical build, dress, neatness, distinctive points

Paragraph 2: Brief Social History

Include information on: background information on applicant, including birthplace, structure of family at birth, and who raised application

Paragraph 3: Education and Work History

Include information on: highest grade completed, vocational training, brief employment history with dates and location, if not employed what are areas of interest and barriers:

Paragraph 4: Psychiatric, Medical, and Substance History

Include information on in-patient/out-patient psychiatric hospitalizations, including where, length of stay. History of homicidal or suicidal ideation or behavior. History of alcohol or substance abuse. List of current medication(s). Outstanding medical problems and treatment/illness or condition that may limit client's ability to live independently or work?

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DYCD TO DHS SHELTER REFERRAL WORKSHEET

asterisk (*) are required fields. If fields don't apply, select N/A

*Last Name	*First	MI	*Date

Have you been tested for TB in the last year?:	Do you have documentation of the results?:
If TB results were positive, was a chest X-Ray performed?:	If yes, when?:
If yes, where was the X-Ray performed?:	
Have you ever been treated for active TB?:	
Have you ever been treated for a positive skin test (only)?:	

Paragraph 5: Current Situation

Include information on: current level of functioning at shelter

Paragraph 6: Summary and Recommendations

Include information on: outstanding features. Summary of recommendation for supportive housing:

Staff Signature	Date

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REASONABLE ACCOMMODATION REQUEST FORM

INSTRUCTIONS: Clients must complete Section I and submit this form along with any supporting documentation to the Program/Facility Director, or functional equivalent ("Director"). DHS and provider staff must offer to help the client with completing this form.

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

Name: _____

Facility/Program: _____

Client ID/SSN: _____ Phone: _____

Describe the Accommodation Requested (attach any supporting documentation).

_____

_____

_____

_____

_____

Section II Instructions: Any Director receiving a completed form with disability-related documentation must complete Section II, return a copy to the client, and immediately transmit by email or fax the request and supporting documents to the appropriate Program Administrator. Supporting documentation is not required if the disability is obvious/apparent or otherwise known to DHS.

Section II: (To be completed by the Facility Director or designee.)

Name/Title: _____

Facility/Program: _____

Address: _____

Phone: _____ Date Received: _____

☐ I discussed the HIPAA form with the client and the client consented to complete a HIPAA form.

☐ I discussed the HIPAA form with the client and the client declined to complete a HIPAA form.

Signature: _____

After completing, provide a copy of this form to the client.

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HIPAA AUTHORIZATION FOR THE DISCLOSURE OF INDIVIDUAL HEALTH INFORMATION

Client Name _____

Date of Birth _____ Case ID Number _____

Last 4 digits of Social Security Number _____

I, or my authorized representative, request that health information about my medical care and treatment be released as outlined below. Federal and state law and regulations, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA) safeguard the privacy of my protected health information (collectively "health records").

Before signing, I understand that:

1. My health records may include confidential **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT** (except psychotherapy notes), and **HIV-RELATED**[1] **INFORMATION**. This information will only be released if I sign my initials in the appropriate boxes in Item 8(a).
2. I can ask for a list of people who may get or use my HIV-related information without my consent. If I suffer discrimination because of the release of HIV-related information, I may contact the New York State Division of Human Rights at **(212) 961-8650** or the New York City Commission on Human Rights at **(212) 306-7450**. They are in charge of protecting my rights.
3. Signing this form is voluntary. If I do not sign it, my treatment, payment to treatment providers, enrollment in a health plan, and eligibility for shelter will not be affected. But, if I do not sign it and I did not submit documentation with my reasonable accommodation request, my reasonable accommodation request may be denied because the NYC Department of Homeless Services (DHS) did not have any supporting documentation or information to review.
4. I can change my mind at any time except for any information that has already been released. To do so, I must tell my shelter or facility director in writing.
5. My health information shared under this consent may be re-released by DHS. The privacy of this information may no longer be protected by federal or state law.

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[1] Human Immunodeficiency Virus causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

PERMISSION TO SHARE HEALTH INFORMATION

6. Name and address of health provider or entity to release this information:

_____

_____

_____

7. This health provider will send this information to: **NYC Department of Social Services, Customized Assistance Services, Office of Reasonable Accommodations, 150 Greenwich Street, 30th floor, New York, NY 10007**.

8(a). Information to be released: **Medical records for the entire year prior to the signature date below**. Include *(Indicate by Initialing)*:

☐ Alcohol/Drug Treatment ☐ Mental Health Information ☐ HIV Related Information

8(b). By initialing here _____, I allow _____
(Initials) (Name of individual health care provider)

to discuss my health information with the **NYC Department of Social Services**.

9. Reason for release of information: **At request of Patient for purpose of reasonable accommodation request only**.

10. Expiration date: **One year from the date of signature**

All items on this form have been completed and my questions about this form have been answered. I was given a copy of the form

_____ _____
Signature of Patient or Authorized Representative by Law Date

_____
If not the Patient, name if individual signing form

_____
Authority to sign on behalf of patient

_____
The best phone number to contact me

INFORMATION ABOUT THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY (HIPAA) CONSENT FORM

This FAQ helps explain the HIPAA consent form and why we are asking you to complete it.

Why should I complete the HIPAA consent form?

Some Reasonable Accommodation Requests (RAR) need a review to decide if it will be approved. The Office of Reasonable Accommodations (ORA) reviews relevant information from your provider to make this determination. Signing the HIPAA consent lets ORA contact your provider when more information is needed to decide about your request. Signing it saves time in the review process.

What information will be collected using this form?

ORA will only ask for information related to the Reasonable Accommodation (RA) that you asked for. Staff will not use the form to contact your provider to get any information unrelated to your request.

How do I complete this form?

- You must fill out, sign, and date the HIPAA consent for it to be valid.
- The HIPAA consent is valid for one year from the date you sign it.
- If you are not able to sign the consent, an authorized representative can sign for you. If an authorized representative is signing for you, you must give us a document that proves their authority, such as a Power of Attorney or Guardianship Commission.

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INFORMATION ABOUT THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY (HIPAA) CONSENT FORM *(continued)*

What if I no longer want ORA to use this form to reach out to my provider?

You can tell us to stop the use of the form at any time, but you must tell the shelter or facility director in writing.

Note: You don't need to sign this consent if you don't want our help getting information from your provider. Instead, you can get relevant information directly from your providers to hand in with your accommodation request.

What if I don't have any documentation?

If you do not have any documentation to submit with the RAR(s), and you do not complete and sign the HIPAA form, your request may be denied because we did not have any supporting documents or information to review.

What if I have more questions about this form?

DHS staff and shelter staff will answer any questions you have about the form and can help you fill it out in person.

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REQUEST FOR CONSULTATION AND INTERVENTION FROM THE DHS OFFICE OF THE MEDICAL DIRECTOR

This form is to be completed by the Site Director or Social Services staff. If there is a clinician affiliated with the site, the clinician (physician, nurse practitioner, PsyD, PhD) must review and approve the request and the form. The form should be submitted to the Program Administrator for review and approval.

Date of Request: _____

CLIENT INFORMATION

Name:_____ DOB: _____ CARES ID Number: _____

Shelter or site name: _____

Site Medical/Clinical Provider *(if applicable)*:

Name: _____ Telephone: _____ Email: _____

What is the specific consultation question for the Medical Director's Office?

_____

Rationale and description of the present situation: _____

_____

Urgency of this request: ☐ Scheduled Discharge Dates ☐ Clinical Meetings
☐ AOT Application Needed ☐ Other _____

Desired outcome: ☐ Admission ☐ Arrange Placement in a Nursing Home
☐ Arrange a Psych Consult ☐ Other _____

Specific action requested: ☐ Liaison with the ED ☐ Call their Primary Case Provider
☐ Speak to the Hospital Social Worker ☐ Other _____

Document diagnosis/main medical, mental health or substance use issues

(including suspected diagnoses): _____

_____

Brief clinical history and key points:

_____

_____

_____

_____

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Has the client been admitted to a psychiatric hospital in the last 10 years? ☐ Yes ☐ No

Does client have outpatient mental health services? ☐ AOT Order ☐ ACT
☐ IMT ☐ Care Coordinator If yes, provide name: _____

Previous actions taken by shelter/DIC/outreach/Safe Haven team:

_____

Previous actions taken by site medical/clinical provider *(if site has one)***:**

_____

Site Clinical Provider Assessment:

_____

If shelter/DIC/outreach/Safe Haven team deemed client medically inappropriate for shelter, list reasons:

_____
_____

For returning clients, did shelter receive and review discharge referral package? ☐ Yes ☐ No

If yes, what was the determination of appropriateness after review?

_____
_____

Client's current location: ☐ Hospital ☐ Shelter ☐ Other: _____

Hospital Social Worker:

Name: _____ Telephone: _____ Email: _____

Treating physician:

Name: _____ Telephone: _____ Email: _____

Covering attending *(if main physician is out)***:**

Name: _____ Telephone: _____ Email: _____

Resident *(if involved)***:**

Name: _____ Telephone: _____ Email: _____