ATTACHMENT A SUPPLEMENTAL FORM FOR DHS INTERIM HOUSING

REFERRING PROGRAM UNIT/TYPE: ☐

Date of Interim Housing Request: ______________________ Date Received by HFH: ______________________

Referring Program/Agency Name:	Referring Program Contact Name and Title:

Main Phone/Mobile for Program Contact Person:	Email Address for Program Contact Person:

Client Name:	DOB:	Social Security # (if known):	Medical Record # (if applicable):

Client Phone/Mobile #:	Client Email Address:

Insurance:
☐ Medi-Cal ☐ Medicare ☐ Medi-Cal/Medicare ☐ VA ☐ Private ☐ Unknown ☐ None ☐ Other: ______________________

Client Demographics (Ethnicity) ☐ Hispanic ☐ Not Hispanic ☐ Ethnicity unknown
(Race): ☐ Asian ☐ American Indian/Alaskan Native ☐ Black/African American ☐ White ☐ Latino ☐ Other ☐ Unknown ☐ Not collected

Completion of this application infers that the client is aware and accepts the terms of placement. Placements are often communal and are based on bed availability. Housing for Health is not able to guarantee geographic placement, single room requests, or special placement requests.

Admission/length of stay: ☐ ED Visit ☐ Other: __________ ☐ Inpatient ☐ N/A Admit Date: ______________ Anticipated Discharge: ______________	If applicable, please explain reason(s) for hospital/other facility admission and any recent surgeries, etc.: ______________________

Known MH DX: ______________________ On medication: ☐ Yes ☐ No **(If yes, please include in Med List)**
Receiving MH care: ☐ Yes ☐ No If yes, location/providers: ______________________

Known SUD (Type): ______________ Receiving SUD care: ☐ Yes ☐ No Location/provider: ______________	On meds (e.g. Methadone/Suboxone): ☐ Yes ☐ No **(If yes, please include in Med List)** Is client at risk of withdrawal: ☐ Yes ☐ No ☐ Unknown If yes, please explain: ______________

Cognitive Impairments (e.g. dementia/developmental delay): ☐ Yes ☐ No Please explain: ______________	Is client at risk for wandering? ☐ Yes ☐ No Can client follow commands to ensure safety? ☐ Yes ☐ No

Continent of Bowel and/or Bladder: ☐ Yes ☐ No
If no, able to self-care: ☐ Yes ☐ No If no, please describe: ______________________

Independent with ADLs: ☐ Yes ☐ No If no, please describe: ______________________

Wound Care Needs: ☐ Yes ☐ No Frequency of wound care: ☐ Once Daily ☐ Twice Daily ☐ Three times Daily If yes, please indicate location/size/stage of all wounds: ______________	Is client able to care for wound(s) independently: ☐ Yes ☐ No Is home health ordered for client: ☐ Yes ☐ No

Seizures: ☐ Yes ☐ No If yes: ☐ Controlled ☐ Uncontrolled Describe: ______________________

Is client on dialysis? ☐ Yes ☐ No If yes, schedule: ______________	Dialysis/Nephrologist name and address: ______________

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Client Name: ___________________________
Client Date of Birth: ______________________

Does client require IV therapy (e.g. antibiotics for osteomyelitis)? ☐ Yes ☐ No If yes, how frequent: ____________________	Ordering provider name: ____________________ Is home health ordered for client: ☐ Yes ☐ No
Is client pregnant: ☐ Yes ☐ No Due date: ______________	Is this a high risk pregnancy? (if applicable): ☐ Yes ☐ No If yes, high risk OB location/name: ____________________

Does client have communicable disease (such as C diff diarrhea, active TB, MRSA or VRE, or Hepatitis A)? ☐ Yes ☐ No
Please explain:
____
____
____
____
____

Any other information related to the client's care and/or needs:
____
____
____
____

Is the client currently taking any medication(s)? If yes, please list (and attach current med list):____________________
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Is the client able to self-administer ALL medications: ☐ Yes ☐ No If no, please explain: ____________________
____

Special Considerations: ☐ History of aggression ☐ Victim of intimate partner violence ☐ Registered sex offender ☐ Convicted of arson
☐ Communicable Conditions (Please list below)

Notes: ____
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Supporting Documentation: For referring hospitals and any medical/mental health/psychiatric/substance use treatment facilities:
Submit the following documentation with the completed ***Supplemental Form for DHS/DMH Interim Housing Program (Attachment A)*** forms to help expedite review of this Interim Housing request:

☐ Face Sheet ☐ History & Physical ☐ Recent MD/Provider Progress Notes ☐ Medication List (NOT MAR) ☐ PT/OT Evaluation (if applicable)
☐ Psych Clearance (if applicable) ☐ D/C Planning Notes ☐ TB Test/Chest X-ray ☐ Other: ____________________

Notes: ____

PLEASE NOTE: If accepted to an Interim Housing placement, the referring agency must make appropriate transportation arrangements to the interim housing facility AND clients will need to bring the following items with them to the designated Interim Housing facility:

☐ 30 Day Supply of ALL Medications ☐ Any Durable Medical Equipment (DMEs) Needed (Wheelchair, walker, cane, C-PAP, etc.) ☐ Follow-up Care Plan and Appointment(s)

Please submit this supplemental form with the completed LAHSA/DHS/DMH Referral Form for Bridge/Interim Housing Program and all applicable supporting documentation to the appropriate agency. Please see page 3 of the LAHSA/DHS/DMH referral form for detailed submission instructions.