ATTACHMENT A
SUPPLEMENTAL INFORMATION 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:		
Program Contact Phone/Mobile #:	Program Contact Email Address:		
Participant Name:	DOB:	Medical Insurance Provider (if known):	Insurance Type (Medicaid, Medi-Cal, etc):
Participant Phone/Mobile #:	Participant Email Address:		

Participant Demographics
(Ethnicity) ☐ Hispanic ☐ Not Hispanic ☐ Ethnicity unknown

Completion of this application infers that the participant 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.: _____

5x5 Score: _____ ☐ Unavailable ☐ **Completed by:** (Name/Agency): _____ **Date**: _____

Medical Conditions: _____
Medical Equipment: _____ Specialized Medical Treatment: _____
Known MH DX: _____ On medication: ☐ Yes ☐ No **(If yes, please include in Med List)**
Mental Health Conditions: ☐ Anxiety Disorder ☐ Bipolar Disorder ☐ Depression ☐ History of 5150 Holds ☐ History of Psychiatric Hospitalizations ☐ Mood Disorder ☐ Personality Disorder (Axis III) ☐ PTSD ☐ Psychosis ☐ Schizoaffective Disorder ☐ Schizophrenia ☐ Suicidal Ideation/Attempted Suicide

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 participant at risk of withdrawal: ☐ Yes ☐ No ☐ Unknown
If yes, please explain: _____

Cognitive Impairments (e.g. dementia/developmental delay/traumatic brain injury): ☐ Yes ☐ No
Please explain: _____

Is participant at risk for wandering? ☐ Yes ☐ No
Can participant follow commands to ensure safety? ☐ Yes ☐ No

Independent with ADLs:

Bathing:	☐ Requires No Assistance	☐ Some Assistance Needed	☐ Complete Assistance Needed	☐ Not Applicable
Dressing:	☐ Requires No Assistance	☐ Some Assistance Needed	☐ Complete Assistance Needed	☐ Not Applicable
Grooming:	☐ Requires No Assistance	☐ Some Assistance Needed	☐ Complete Assistance Needed	☐ Not Applicable
Mouth Care:	☐ Requires No Assistance	☐ Some Assistance Needed	☐ Complete Assistance Needed	☐ Not Applicable
Bowel/Bladder:	☐ Requires No Assistance	☐ Some Assistance Needed	☐ Complete Assistance Needed	☐ Not Applicable
Transfers:	☐ Requires No Assistance	☐ Some Assistance Needed	☐ Complete Assistance Needed	☐ Not Applicable
Ambulation:	☐ Requires No Assistance	☐ Some Assistance Needed	☐ Complete Assistance Needed	☐ Not Applicable
Eating:	☐ Requires No Assistance	☐ Some Assistance Needed	☐ Complete Assistance Needed	☐ Not Applicable

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Participant Name: _____
Participant Date of Birth: _____

Independent with iADLs:

Shopping for Food/Errands: ☐ Requires No Assistance ☐ Some Assistance Needed ☐ Complete Assistance Needed ☐ Not Applicable

Cooking: ☐ Requires No Assistance ☐ Some Assistance Needed ☐ Complete Assistance Needed ☐ Not Applicable

Managing Medications: ☐ Requires No Assistance ☐ Some Assistance Needed ☐ Complete Assistance Needed ☐ Not Applicable

Using Phone/Computer: ☐ Requires No Assistance ☐ Some Assistance Needed ☐ Complete Assistance Needed ☐ Not Applicable

Doing Housework: ☐ Requires No Assistance ☐ Some Assistance Needed ☐ Complete Assistance Needed ☐ Not Applicable

Doing Laundry: ☐ Requires No Assistance ☐ Some Assistance Needed ☐ Complete Assistance Needed ☐ Not Applicable

Driving/Public Transportation: ☐ Requires No Assistance ☐ Some Assistance Needed ☐ Complete Assistance Needed ☐ Not Applicable

Managing Finances: ☐ Requires No Assistance ☐ Some Assistance Needed ☐ Complete Assistance Needed ☐ Not Applicable

Medical Equipment: ☐ Requires No Assistance ☐ Some Assistance Needed ☐ Complete Assistance Needed ☐ Not Applicable

Prosthetic Devices: ☐ Requires No Assistance ☐ Some Assistance Needed ☐ Complete Assistance Needed ☐ Not Applicable

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 & who is providing wound care supplies: _____
_____
_____

Is participant able to care for wound(s) independently: ☐ Yes ☐ No

Is home health ordered for participant: ☐ Yes ☐ No

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

Is participant on dialysis? ☐ Yes ☐ No

If yes, schedule: _____

Dialysis/Nephrologist name and address: _____
_____
_____

Does participant require IV therapy (e.g. antibiotics for osteomyelitis)? ☐ Yes ☐ No

If yes, how frequent: _____

Ordering provider name: _____

Is home health ordered for participant: ☐ Yes ☐ No

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

Participant Health Information: Height: _____ Weight: _____ Allergies: _____
Does participant have any disabilities? ☐ Blind ☐ Deaf ☐ Literacy ☐ Physical

Any other information related to the participant's care and/or needs:
_____
_____
_____

Is the participant currently taking any medication(s)? If yes, please list (and attach current med list): _____
_____

Is the participant able to self-administer ALL medications: ☐ Yes ☐ No If no, please explain: _____
_____

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Special Considerations: ☐ History of aggression ☐ Victim of intimate partner violence ☐ Registered sex offender ☐ Convicted of arson ☐ Communicable Conditions (Lice/Scabies*)

Notes: _____

*** All medications, including topical and over the counter treatments, must be provided to the participant upon discharge. The participant will need to be these medications to be admitted to facility and appropriate precautions will need to be taken for transportation of participants and belongings.**

Supporting Documentation: For referring hospitals and any medical/mental health/psychiatric/substance use treatment facilities:
Submit the following documentation with the completed ***Supplemental Information Form for DHS/DMH Interim Housing Program (Attachment A)*** forms to help expedite review of this Interim Housing request:
* Reminder- All private hospitals must submit recuperative care referrals to the participant's MCP (LA Care, Blue Shield, HealthNet, Molina, Kaiser, Anthem) prior to submission to HFH.

☐ Face Sheet ☐ History & Physical ☐ Recent MD/Consultation/Progress Notes ☐ Medication List (NOT MAR) ☐ PT/OT Evaluation (if applicable) ☐ Psych Clearance (if applicable) ☐ D/C Planning Notes ☐ TB Test/Chest X-ray ☐ Covid-19 Test ☐ Other: _____

☐ SW Notes: _____

☐ Wound Care Notes (if applicable): _____

Notes: _____

PLEASE NOTE: If accepted to an Interim Housing placement, the referring agency must make appropriate transportation arrangements to the interim housing facility AND participants 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 1 of the LAHSA/DHS/DMH referral form for detailed submission instructions.