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: _____

Participant Contact Phone/Mobile #: _____ Participant Email Address: _____

Social Security # (if known): _____ Medical Record # (if applicable): _____

Participant 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 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 ☐ Inpatient ☐ N/A ☐ Other: _____

Admit Date: _____ Anticipated Discharge Date: _____

If applicable, please explain reason(s) for hospital/other facility admission and any recent surgeries, etc.: _____

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

Known MH DX: _____ On meds: ☐ Yes ☐ No **(If yes, include in Med List)**

Receiving MH care: ☐ Yes ☐ No If yes, location/provider: _____

Known SUD (Type): _____ On meds (e.g. Methadone/Suboxone): ☐ Yes ☐ No **(If yes, include in Med List)**

Receiving SUD care: ☐ Yes ☐ No If yes, location/provider: _____

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

Cognitive Impairments (e.g. dementia/developmental delay): ☐ Yes ☐ No If yes, please explain: _____

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

Independent with ADLs: ☐ Yes ☐ No If no, please explain: _____

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 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

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Participant Name: _____ Participant DOB: _____

Does participant 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 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: _____

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 these medications to be admitted to the 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 Interim Housing (Attachment A)*** to help expedite review of this Interim Housing request:

☐ Face Sheet ☐ History & Physical ☐ Recent MD/Provider Progress Notes ☐ Medication List (NOTE MAR)

☐ D/C Planning Notes ☐ Psych Clearance (if applicable) ☐ PT/OT Evaluation (if applicable) ☐ 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 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 Information Form with the completed DHS/DMH/LAHSA Referral Form for Interim Housing Programs and all applicable supporting documentation to DHS Interim Housing Administration. Please see page 1 of the DHS/DMH/LAHSA Referral Form for Interim Housing Programs for detailed submission instructions.