HOUSING FOR HEALTH

Los Angeles County Department of Health Services (DHS)
Housing For Health

Interim Housing Programs

Juataun Mark, MPA – Director

July 16, 2019

Health Services
LOS ANGELES COUNTY

Interim Housing Program:

DHS Interim Housing Programs-serves individuals with complex health and/or behavioral health conditions who need a higher level of support services than is available in most shelter settings. Program offers temporary housing in a stable environment to assist clients in increasing independence and completing housing goals.

Stabilization

- Medically and psychiatrically stable individuals who may be vulnerable to decompensation if not placed into shelter housing.

- *Common Health Conditions:*
  - ✓ HIV/AIDS
  - ✓ Diabetes
  - ✓ Hepatitis
  - ✓ Mental Health (e.g. Schizophrenia, Depression, Bipolar, etc.)
  - ✓ ETOH

Recuperative Care

- Medically and psychiatrically stable patients requiring low-level medical oversight for:
  - ✓ Wound care
  - ✓ Recovery from surgical procedure
  - ✓ Need additional time to recuperate from illness and/or injury

- *Common Health Conditions:*
  - ✓ End Stage Renal Disease
  - ✓ Congestive Heart Failure (EF > 20%)
  - ✓ Cancer
  - ✓ Decubitus (Stages I-III)

Interim Housing Program:

- Who is eligible for Interim Housing?

  - ✓ *Individuals* exiting institutions include jails, prisons, foster care, hospitals, urgent care centers and other medical, behavioral health, and substance abuse treatment facilities
  - ✓ *Individuals* currently homeless on the streets
  - ✓ *Individuals* eighteen years of age or older and families with minor children

- Referral Pathways

Dept. of Health Services Hospitals and Clinics	Coordinated Entry System	Street Based Engagement Outreach Teams
Private Hospitals	Jails/Custody Settings	Mental Health Providers
Substance Use Disorder Providers	Homeless Service Providers	+More

Interim Housing Programs Support Services

Coordinates services with HFH partners to assist participant with:

- ***Room and Board***
  - ✓ 3 meals per day
  - ✓ Allow clients to stay in facility 24/7 days a week
  - ✓ Hygiene supplies
  - ✓ Laundry services
  - ✓ Secured/personal storage for medication
  - ✓ Case Management, Mental Health, Medication Support, Recuperative Care & Transportation services

- ***Case Management Services***
  - ✓ Engagement, assessments of clients' needs, & ongoing monitoring
  - ✓ Assistant with obtaining Identification, birth certificate
  - ✓ Assistance and advocacy with benefits
  - ✓ Maintain regular contact with clients permanent housing ICMS
  - ✓ Assistance with life skills and community re-integration, including social programming

- ***Mental Health/Behavioral Health Services***
  - ✓ Full biopsychosocial assessment
  - ✓ Mental Health treatment and substance abuse counseling
  - ✓ Regular ongoing evaluations and monitoring of mental health status

- ***Medication Support Services***
  - ✓ Assist with medication support and adherence to treatment/care plans
  - ✓ Ensuring participants have access to medication on a timely basis
  - ✓ Maintain list of prescribed medication and sufficient quantities

Health Services
LOS ANGELES COUNTY

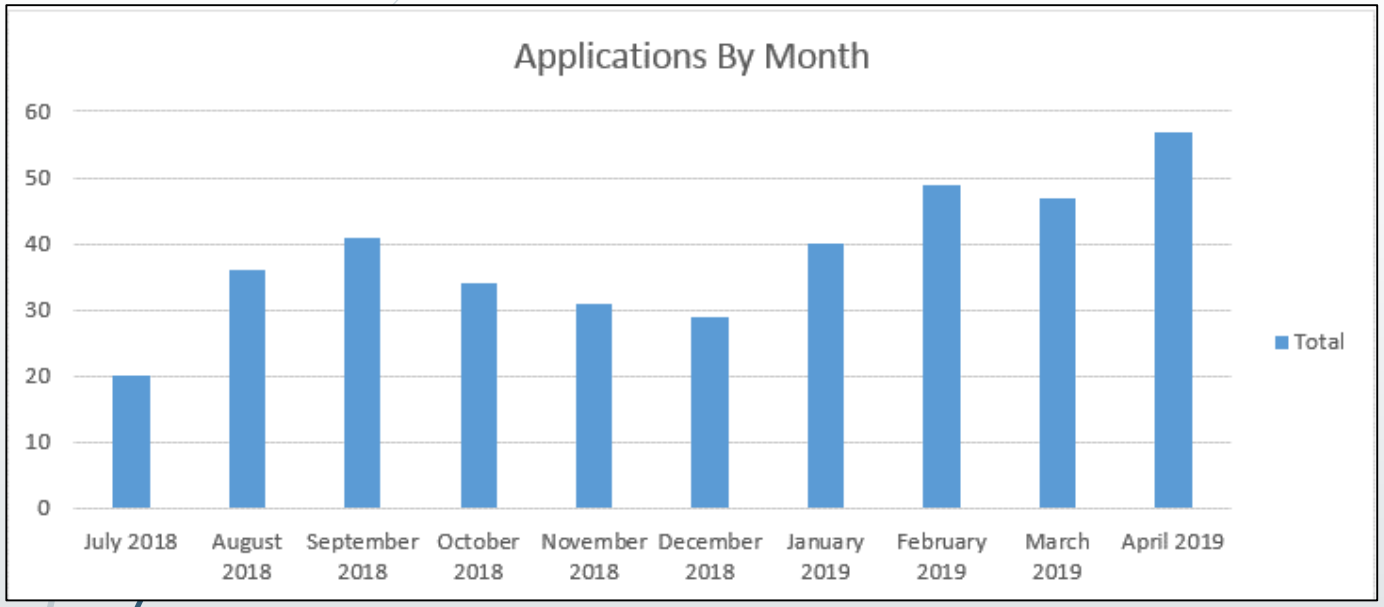
HOUSING FOR HEALTH

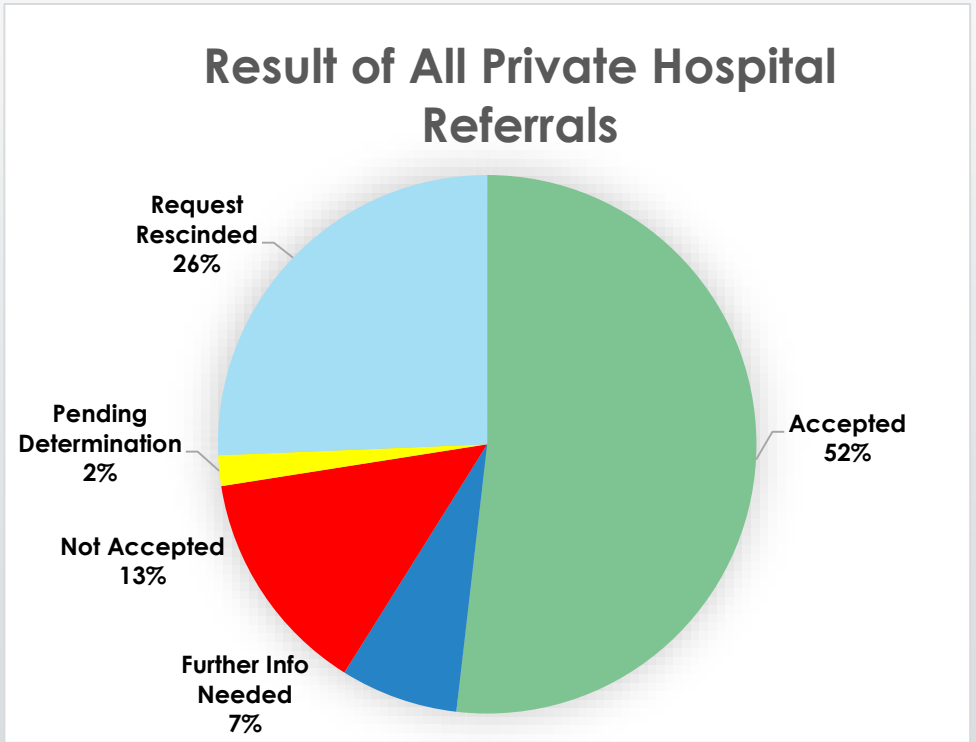
Referrals at a Glance:

Savanah Walseth, HFH Program Manager

Health Services
LOS ANGELES COUNTY

Private Hospital Data…





HOUSING FOR HEALTH

Making a Good Referral:

Rosanna Clarito, Registered Nurse, HFH

Health Services
LOS ANGELES COUNTY

Making a Good Referral….

- *Required Documentation*
  - ✓ New Referral Forms
  - ✓ New Authorization Forms

- *Coming from a medical inpatient setting*
  - ✓ Face Sheet
  - ✓ History & Physical and Most Recent Physician Progress Notes
  - ✓ Current Medication List
  - ✓ Occupation Therapy (OT)/Physical Therapy (PT) Notes
  - ✓ Psychiatric/Mental Health Notes (if applicable)
  - ✓ Follow-Up Appointments (if applicable)
  - ✓ TB Test/Chest X-ray
  - ✓ Other documentation as requested

- *What We Need To Know*
  - ✓ Mobility (e.g., paraplegic, wheelchair, walker/cane, cannot climb stairs)
  - ✓ Pet(s) – Emotional Support/ Service Animals
  - ✓ Area CANNOT live in
  - ✓ Register Sex Offender (RSO) – nature and date of the offense
  - ✓ Arson history (past or present)
  - ✓ Behavior Issues (e.g., aggression – past & present history)
  - ✓ Ability to Live Independently - ADLs & IADLs
  - ✓ Cognitive Impairments (affect on functioning)
  - ✓ Mental Health issues
  - ✓ Assistance with medication

HOUSING FOR HEALTH

The Referral Process:

Rasheena Buchanan, HFH Program Manager

Health Services
LOS ANGELES COUNTY

Referral Guidelines…

DHS/DMH/LAHSA REFERRAL GUIDELINES FOR INTERIM HOUSING PROGRAMS

OVERVIEW

The Interim Housing programs (Crisis/Interim/Bridge/Recovery Bridge/Stabilization/Recuperative Care) administered by the Department of Health Services (DHS), Department of Mental Health (DMH) and the Los Angeles Homeless Services Authority (LAHSA) provide individuals who are experiencing homelessness with a short-term place to stay along with supportive services while they transition to permanent housing. Interim Housing providers offer all participants a safe and clean shelter, 24-hour general oversight, three meals each day, clean linens, clothing, toiletries and case management services. Some Interim Housing providers are contracted to provide additional on-site services including medical oversight, health monitoring, mental health and/or behavioral health services and transportation assistance. Interim Housing facilities may also target specific populations such as families with minor children, older adults, women, transition age youth and individuals/families fleeing domestic violence.

PARTICIPANT ELIGIBILITY CRITERIA

1. Age 18 or older
2. Homeless
3. Presents with a complex health condition, a mental illness and/or other vulnerabilities
4. Able and willing to self-administer medication
5. Independent with all Activities of Daily Living (ADLs) including bathing, grooming, dressing, feeding and toileting
6. Independent with mobility/transfers and the safe use of Durable Medical Equipment (DME) such as walkers, wheelchairs and other assistive devices
7. Continent of bowel and bladder or independent with the use of incontinence supplies
8. Cognitively alert and oriented to name, place, date and situation
9. ***DMH INTERIM HOUSING PROGRAM ONLY:***
   a. Participants must present with a mental illness.
   b. Participants must be receiving or willing to receive mental health services from a DMH directly-operated clinic or contract provider and be willing to sign an Interim Housing Program Client Agreement.
   c. Refer DMH Transition Age Youth (TAY) (ages 16-25) to the TAY Enhanced Emergency Shelter Program gatekeeper by calling 213-738-6194.
10. ***SELECT LAHSA BRIDGE HOUSING PROGRAMS ONLY:***
    a. Participants must meet criteria for HUD Homeless Category 1 or 4 AND
       - Be enrolled in Rapid Rehousing or matched to another Permanent Supportive Housing resource OR
       - Have a Coordinated Entry System (CES) Survey Packet acuity score of eight or higher OR
       - Present with other qualifying vulnerabilities (see Appendix A for additional participant eligibility criteria and referral guidelines).

NOTE: *While participants may meet eligibility criteria for more than one program, submit only one referral per participant. Based on the participant's needs, DHS, DMH and LAHSA may consult with each other to determine the most appropriate placement for the participant.*

PARTICIPANT EXCLUSION CRITERIA *(including but not limited to the below)*

1. Requires psychiatric or physical health emergency/inpatient hospitalization or other 24-hour treatment
2. Requires daily physician oversight for acute care needs or 24-hour nursing support
3. Requires Skilled Nursing Facility (SNF) level of care, acute physical rehabilitation services, licensed residential care or other 24/7 care and supervision
4. Currently exhibits combative, aggressive or threatening behavior
5. Has cognitive impairments that require constant supervision, monitoring, redirection or verbal cues or that place the participant at risk of wandering
6. Needs or is on mental health conservatorship
7. Has wounds/ulcers that require more than two (2) dressing changes per day

REFERRING ENTITY RESPONSIBILITIES

1. Communicate with the participant about the referral to ensure they are willing to accept Interim Housing.
2. Review the Referral Submission Instructions on the DHS/DMH/LAHSA Referral Form for Interim Housing Programs to determine whether the participant should be referred to DHS, DMH or LAHSA.
3. Complete the DHS/DMH/LAHSA Referral Form for Interim Housing Programs including any supplemental forms and submit to the appropriate department/agency.
   a. Referrals to DHS initiated by a medical, mental health and/or behavioral health facility require additional supporting documentation including, but not limited to, the participant's face sheet, medication list, medical history, physical examination results, most recent progress notes from a MD/physical therapist/occupational therapist/other service provider, discharge planning notes, follow-up appointment information and/or other pertinent information for placement.
   b. Referrals to LAHSA also require verification of homeless status and health documentation as applicable to the placement (e.g., TB screening results, County health releases, etc.).
4. If the participant is being re-referred to Interim Housing and it has been more than 30 days since they left their last placement, complete and submit a new DHS/DMH/LAHSA Referral Form for Interim Housing Programs.

DHS/DMH/LAHSA INTERIM HOUSING ADMINISTRATIVE RESPONSIBILITIES

1. DHS/DMH/LAHSA Interim Housing Administration will review the referral for program eligibility and contact the referring entity if the referral is incomplete or requires additional documentation. Incomplete referrals may cause delays in processing.
2. DHS/DMH/LAHSA Interim Housing Administration will notify the referring entity on whether there is an available bed or if the participant will be placed on a wait list.

INTERIM HOUSING ADMISSION REQUIREMENTS

1. Date and Time of Arrival
   a. The participant must arrive at the Interim Housing facility between 8:00 a.m. - 3:00 p.m. within one business day following receipt of the placement email confirmation from DHS/DMH/LAHSA Interim Housing Administration. If not, the bed will become available to another participant.
      - Exceptions to the arrival timeframe may be made on a case-by-case basis with the Interim Housing provider.
      - Exceptions to the arrival date must be pre-approved by DHS/DMH/LAHSA Interim Housing Administration.
   b. The referring entity is responsible for transportation of the participant (unless they have a car) to the Interim Housing facility and they must coordinate the participant's date and time of arrival with the Interim Housing provider **prior** to transporting the participant.
2. Medication/Assistive Devices
   a. At the time of arrival to the Interim Housing facility, the referring entity must ensure that the participant has a 30-day supply of any medications and any necessary DMEs or other assistive devices with them.
3. Service and Emotional Support Animals
   a. Under the Americans with Disabilities Act (ADA), Interim Housing facilities must permit service animals.
   b. Participants with emotional support animals may be requested to provide vaccination records and/or a note from a mental health professional.

NOTE FOR MEDICAL FACILIITES: *If the participant has been accepted to an Interim Housing facility and it is determined post-arrival that the participant is not appropriate for the Interim Housing program or did not arrive with their required medications and/or necessary assistive devices, the participant may be sent back to the referring medical facility within 48 hours of arrival.*

ADDITIONAL PARTICIPANT ELIGIBILITY CRITERIA AND REFERRAL GUIDELINES FOR SELECT LAHSA BRIDGE HOUSING PROGRAMS* (APPENDIX A)

A BRIDGE HOME

- Participants must be living in a place not meant for human habitation within a Council District's identified catchment area and/or the city of Los Angeles
- Submit the referral for A Bridge Home as directed below:
  - Prior to opening and through the first 30 days of program operation, submit the referral to the SPA Outreach Coordinator.
  - After the first 30 days of program operation, submit the referral to the Countywide Interim Housing Matcher.

BRIDGE HOUSING FOR PERSONS EXITING INSTITUTIONS

- Participants must have exited from an institution in the past 60 days.
  - Eligible institutions include but are not limited to: jails, prisons, foster care, detention centers, residential care facilities or substance use treatment facilities.
- Submit documentation substantiating the exit from the eligible institution within the first 90 days of program enrollment.

ENHANCED BRIDGE HOUSING FOR WOMEN

- Participants must identify as a woman. This is inclusive of both cis-sexual and trans-identifying persons.
- Eligibility is then based on:
  - Whether the identifying participant is Bridge Housing Program eligible (based on homeless status, CES acuity score and/or enrollment in Rapid Rehousing/match to a Permanent Housing resource); AND/OR
  - Whether the person has past trauma and would benefit from Licensed Clinical Case Management from a women's site.

ENHANCED BRIDGE HOUSING FOR OLDER ADULTS

- Participants must be age 55 or older.
- Eligibility is then based on:
  - Whether the identifying participant is Bridge Housing Program eligible (based on homeless status, CES acuity score and/or enrollment in Rapid Rehousing/match to a Permanent Housing resource); AND/OR
  - Whether the person has past trauma and would benefit from Licensed Clinical Case Management from an older adults' site.
- Submit documentation substantiating the participant's age within the first 90 days of program enrollment.

***Information on how to refer to other LAHSA Interim Housing programs, including other Bridge Housing Programs, can be found at https://www.lahsa.org/documents?id=2196-lahsa-shelter-list.pdf. For referral coordination or questions, email interimhousing@lahsa.org.**

New Universal Referral Forms …

DHS/DMH/LAHSA REFERRAL FORM FOR INTERIM HOUSING PROGRAMS

****REFERRAL SUBMISSION INSTRUCTIONS - REFER TO ONE PROGRAM ONLY****

DHS INTERIM HOUSING PROGRAM

A. IF REFERRING ENTITY IS A PRIVATE OR COUNTY HOSPITAL OR DHS FUNDED COMMUNITY-BASED ORGANIZATION OR OTHER NON-DMH FUNDED PROGRAM AND THE PARTICIPANT'S PRESENTING ISSUE IS MEDICAL:

- Review the DHS/DMH/LAHSA Referral Guidelines for Interim Housing Programs to ensure participant meets the eligibility criteria.
- Complete the DHS/DMH/LAHSA Referral Form for Interim Housing Programs and Supplemental Information Form for DHS Interim Housing (Attachment A).
- Complete the Authorization for the Use and Disclosure of Health and Social Service Information and obtain participant signature.
- If applicable, obtain the additional supporting documentation described in the DHS/DMH/LAHSA Referral Guidelines for Interim Housing Programs.
- Submit the above documents to InterimHousing@dhs.lacounty.gov or fax to (213) 895-0100.

***If referring entity is a DHS hospital/facility/outreach team/ICMS or ODR provider, use the online CHAMP application to apply for Interim Housing. Do not use the DHS/DMH/LAHSA Referral Form for Interim Housing Programs.**

DMH INTERIM HOUSING PROGRAM

B. IF REFERRING ENTITY IS A DMH DIRECTLY-OPERATED CLINIC/CONTRACT PROVIDER/OUTREACH TEAM OR OTHER NON-DHS FUNDED PROGRAM AND THE PARTICIPANT'S PRIMARY PRESENTING ISSUE IS MENTAL ILLNESS:

- Review the DHS/DMH/LAHSA Referral Guidelines for Interim Housing Programs to ensure participant meets the eligibility criteria.
- Complete the DHS/DMH/LAHSA Referral Form for Interim Housing Programs.
- Complete the Authorization for Use or Disclosure of Protected Health Information form and obtain participant signature.
- Submit the above documents to IHP@dmh.lacounty.gov.

SELECT LAHSA BRIDGE HOUSING PROGRAMS ONLY*

C. IF REFERRING ENTITY IS A NON-DHS OR NON-DMH PROGRAM:

- Use the referral process described in Section A *if participant presents with a significant medical issue*.
- Use the referral process described in Section B *if participant presents with a significant mental health issue and is willing to accept mental health services*.
- *If participant does not present with a significant medical or mental health issue,* review the DHS/DMH/LAHSA Referral Guidelines for Interim Housing Programs to determine if they meet the eligibility criteria for any of the following LAHSA Bridge Housing programs:
  - A Bridge Home
  - Bridge Housing for Persons Exiting Institutions
  - Enhanced Bridge Housing for Women
  - Enhanced Bridge Housing for Older Adults
- Complete the DHS/DMH/LAHSA Referral Form for Interim Housing Programs if eligibility criteria is met.
- Submit the above document to interimhousing@lahsa.org. *(Signed authorizations are not required for LAHSA Bridge Housing.)*

***Information on how to refer to other LAHSA Interim Housing programs, including other Bridge Housing Programs, can be found at https://www.lahsa.org/documents?id=2196-lahsa-shelter-list.pdf.**

ALL REFERRING ENTITIES

D. IF PARTICIPANT PRESENTS ONLY WITH A SUBSTANCE USE ISSUE AND IS INTERESTED IN SUBSTANCE USE TREATMENT:

- Contact the Substance Abuse Service Hotline at (844) 804-7500 to request access to substance use treatment including outpatient and residential services.

REFERRING ENTITY INFORMATION

Date of Referral: _____ Name of Referring Entity: _____

Referring Staff Name: _____ Referring Staff Title: _____

Referring Staff Phone Number: _____ Referring Staff Email Address: _____

Alternate Contact Name: _____ Alternate Contact Title: _____

Alternate Contact Phone Number: _____ Alternate Contact Email Address: _____

Referring Entity Type:

☐ Private Hospital ☐ Private Non-DHS Urgent Care ☐ Jail/Custody Setting (Non-ODR) ☐ Skilled Nursing Facility

☐ CBEST Program ☐ Mental Health Outpatient Treatment Facility ☐ Substance Use Disorder Residential Treatment Facility

☐ Substance Use Disorder Outpatient Treatment Facility (including Withdrawal Management Program)

☐ Street-Based Outreach Program, specify: ☐ LAHSA Outreach Team ☐ DMH Outreach Team ☐ DHS Outreach Team

If Street-Based Outreach Program, select Outreach Team name.

☐ SPA 1 - MHA LA	☐ SPA 4 - C3 Skid Row Team (Blue)	☐ SPA 5 - St. Joseph Center
☐ SPA 1 - LAFH	☐ SPA 4 - The People Concern	☐ SPA 6 - HOPICS
☐ SPA 2 - LAFH	☐ SPA 4 - The Center at Blessed Sacrament	☐ SPA 6 - SSG MLK Campus
☐ SPA 2 - SFVCMHC, Inc.	☐ SPA 4 - Homeless Health Care LA	☐ SPA 6 - SSG CD8
☐ SPA 3 - USHS	☐ SPA 4 - Exodus Recovery NELA	☐ SPA 7 - PATH
☐ SPA 4 - C3 Skid Row Team (Red)	☐ SPA 4 - Exodus/LAC + USC Team	☐ SPA 8 - MHA LA
☐ SPA 4 - C3 Skid Row Team (Purple)	☐ SPA 5 - C3 Venice Team	☐ SPA 8 - Harbor UCLA Campus Team
☐ SPA 4 - C3 Skid Row Team (Yellow)	☐ SPA 5 - C3 Santa Monica Team	☐ PATH Metro Red Line Team

☐ Other, specify: _____

☐ DHS ICMS Provider and participant is not being served by one of the above entities.

☐ Other referring entity, specify: _____

PARTICIPANT INFORMATION

Participant Name (First, Middle, Last): _____ DOB: _____ Age: _____

HMIS # (if known): _____ CHAMP ID # (if known): _____ IBHIS # (if known): _____

CES Acuity Score: _____ CES Score is for a: ☐ Youth/Adult ☐ Family Matched to Housing Resource? ☐ Yes ☐ No

Gender: ☐ Male ☐ Female ☐ Trans Man ☐ Trans Woman ☐ Other: _____

Pronoun Preference: ☐ She/Her ☐ He/Him ☐ They/Them ☐ Other: _____

Primary Language Spoken: _____ Limited English proficiency requiring translation services? ☐ Yes ☐ No

Participant Phone Number: _____ Participant Email Address: _____

Participant Current Location:

☐ SPA 1 - Antelope Valley ☐ SPA 2 - San Fernando Valley ☐ SPA 3 - San Gabriel Valley ☐ SPA 4 - Metro LA

☐ SPA 5 - West LA ☐ SPA 6 - South LA ☐ SPA 7 - South East LA ☐ SPA 8 - South Bay/Long Beach

If in City of LA jurisdiction, specify address or cross streets where participant typically resides: _____

Is participant on: ☐ Probation ☐ AB 109 Probation ☐ Parole ☐ Non-Revocable Parole (Does not report to Parole Agent) ☐ N/A

Is participant conserved or does participant have a conservatorship hearing pending? ☐ Yes ☐ No

If yes, type of conservatorship: ☐ LPS ☐ Probate

New Universal Referral Forms cont…

Participant Name: _____ HMIS/CHAMP/IBHIS ID#: _____

HOUSEHOLD INFORMATION
(Only complete if participant is requesting to be housed with family)

Minor Children

Name: _____ DOB: _____ Legal Custody: ☐ Yes ☐ No
Name: _____ DOB: _____ Legal Custody: ☐ Yes ☐ No
Name: _____ DOB: _____ Legal Custody: ☐ Yes ☐ No
Name: _____ DOB: _____ Legal Custody: ☐ Yes ☐ No
Name: _____ DOB: _____ Legal Custody: ☐ Yes ☐ No
Name: _____ DOB: _____ Legal Custody: ☐ Yes ☐ No

(If there are more minor children to be housed with participant, provide the above requested information in the "Additional Information" section below.)

Additional Adults in Household

Name: _____ DOB: _____ Gender: _____ Qualified Dependent*: ☐ Yes ☐ No
Name: _____ DOB: _____ Gender: _____ Qualified Dependent*: ☐ Yes ☐ No

*Qualified dependents are over age 18, incapable of employment due to mental/physical disability and dependent upon the participant for financial support.
(If there are more adult individuals to be housed with participant, provide the above requested information in the "Additional Information" section below.)

Is the participant pregnant? ☐ Yes ☐ No If yes, how many weeks? _____

Are any other members of the household pregnant? ☐ Yes ☐ No If yes, relationship to participant: _____

Additional Information: _____

PRESENTING ISSUE(S)

Select all that apply to the participant.

☐ Medical, specify: _____ Primary Issue? ☐ Yes ☐ No
*If medical is the participant's primary issue, provide additional details on the DHS Supplemental Information Form (Attachment A).
☐ Mental Health, specify: _____ Primary Issue? ☐ Yes ☐ No
☐ Recent Substance Use, specify: _____ Primary Issue? ☐ Yes ☐ No
☐ Cognitive Impairments , specify: _____ Primary Issue? ☐ Yes ☐ No
☐ Other, specify: _____ Primary Issue? ☐ Yes ☐ No
☐ Participant does not have any of the above issues.

If there is an urgent issue needing immediate attention, specify: _____

TUBERCULOSIS (TB) SCREENING

1. Has the participant had a cough recently that has lasted longer than 3 weeks? ☐ Yes ☐ No ☐ Don't Know
2. Has the participant recently lost weight without explanation during the past month? ☐ Yes ☐ No ☐ Don't Know
3. Has the participant had frequent night sweats during the past month, soaking their sheets or clothing? ☐ Yes ☐ No ☐ Don't Know
4. Has the participant coughed up blood in the past month? ☐ Yes ☐ No ☐ Don't Know
5. Has the participant been feeling much more tired than usual over the past month? ☐ Yes ☐ No ☐ Don't Know
6. Has the participant had fevers almost daily for more than one week? ☐ Yes ☐ No ☐ Don't Know

If participant has a prolonged cough (> 3 weeks) AND answers yes to any other TB screening question, participant must be promptly referred to a health care provider for an evaluation.

TB Test Performed: ☐ Yes ☐ No Date Completed: _____ Results: _____
Chest X-Ray Performed: ☐ Yes ☐ No Date Completed: _____ Results: _____

Participant Name: _____ HMIS/CHAMP/IBHIS ID#: _____

ADDITIONAL PARTICIPANT/HOUSEHOLD INFORMATION

Select all that apply to the participant.

☐ Incontinent and unable to self-care ☐ Respiratory issues (e.g., Supplemental Oxygen) ☐ Needs reminders to take medication
☐ Needs assistance with Activities of Daily Living (e.g., eating, grooming, restroom use) ☐ Significant visual impairment
☐ Significant auditory impairment
☐ Other additional information, specify: _____

Mobility Limitations (Select all that apply to any household member.)

☐ Cannot climb stairs ☐ Uses walker/cane/crutches ☐ Uses motorized wheelchair ☐ Uses manual wheelchair
☐ Cannot transfer (e.g., from wheelchair to bed) ☐ Requires a bottom bunk ☐ Other, specify: _____

Assistance Animals/Pets (Only complete if the participant/household has any animals that will accompany them into Interim Housing.)

1. Is the animal a service animal? ☐ Yes ☐ No Type: _____
2. Is the animal an emotional support animal? ☐ Yes ☐ No If yes, # of animals: _____ Type(s): _____
3. Is the animal a pet? ☐ Yes ☐ No If yes, # of animals: _____ Type(s): _____

CURRENT SLEEPING/LIVING ARRANGEMENT

Select the category that best describes the participant's current sleeping/living arrangement.

☐ Sleeping in a place not meant for human habitation, specify:
☐ Street ☐ Park ☐ Campground ☐ Vehicle ☐ Other, specify: _____
☐ Shelter/Interim Housing
☐ Hotel/Motel fully or partially subsidized by a public or non-profit agency
☐ Exiting an institution (Jail/Prison, Foster Care, Detention Center, Residential Care Facility or Substance Use Treatment Facility) where the participant has resided for:
☐ 90 days or less
☐ More than 90 days AND participant resided in Shelter/Interim Housing or a place not meant for human habitation before entering the institution
☐ Fleeing/attempting to flee domestic violence, human trafficking or sex trafficking
☐ Staying temporarily with family/friends
☐ Other sleeping/living arrangement, specify: _____

INTERIM HOUSING PLACEMENT LOCATION

1. Is participant willing to reside in a communal living environment? ☐ Yes ☐ No (Most Interim Housing sites are communal living environments.)
2. Is participant willing to reside in the Skid Row area? ☐ Yes ☐ No
3. Is there any SPA(s) where the participant CANNOT live in Interim Housing? Select all that apply.

☐ SPA 1 - Antelope Valley ☐ SPA 2 - San Fernando Valley ☐ SPA 3 - San Gabriel Valley ☐ SPA 4 - Metro LA
☐ SPA 5 - West LA ☐ SPA 6 - South LA ☐ SPA 7 - South East LA ☐ SPA 8 - South Bay

For DMH Interim Housing Program participants:

1. Does participant have an Interim Housing provider preference? ☐ Yes ☐ No If yes, please specify: _____
2. Is participant willing to go to an alternate provider? ☐ Yes ☐ No

New Universal Consent Forms…

COMPANION TO THE AUTHORIZATION FOR THE USE AND DISCLOSURE OF HEALTH AND SOCIAL SERVICE INFORMATION

Overview of this Form

This document describes what is on the Authorization for the Use and Disclosure of Health and Social Services Information ("Authorization Form").

The County of Los Angeles Department of Health Services ("DHS") operates a social services and health information exchange to allow your information to be shared among partners in the County's Community Health and Integrated Programs (CHIP).

CHIP helps people get resources and services to improve their health. It coordinates health-care related assistance and social services support. CHIP includes:

- Whole Person Care Los Angeles
- Housing For Health
- Office of Diversion and Re-entry
- Countywide Benefits Entitlement Services Team (CBEST)
- Correctional Health Services – Care Transitions Unit

Many types of organizations work with CHIP, some as subcontractors, including:

- Health care providers
- Mental health providers
- Substance Use Disorder providers
- Social services providers
- Housing providers
- Health plans
- Those involved with the Justice system
- Legal Providers
- Community groups

These providers serve participants in CHIP. The goal of these programs is to improve your health.

Why do you need to share my information?

- To see if you are eligible for programs or resources
- To enroll you in programs
- To coordinate your care and treatment
- To communicate and work with your treating providers and organizations
- To connect you with social services
- Provide you with services
- To receive payment for services we provide
- To improve and evaluate our programs

COMPANION TO THE AUTHORIZATION FOR THE USE AND DISCLOSURE OF HEALTH AND SOCIAL SERVICE INFORMATION

- For reporting purposes
- For other County program activities

Signing the Authorization Form allows CHIP to receive, use and share your information. We only share your information to best help you.

Who can provide my information to the DHS SSHIE for CHIP?

- Your current, past, and future treating providers and organizations, and the California Department of Public Social Services.

Who can use my information?

- Providers working in CHIP and their partners and subcontractors (see above)
- Other providers involved in your care, including:
  - Past provider
  - Current providers
  - Future providers
- DHS SSHIE and other such exchanges operated by or with participation from the County
- CHIP, including CHIP partners and subcontractors, and other organizations that work with CHIP, which are listed in Attachment A.

What are Health Information Exchanges?

- They are electronic systems that allow data sharing.

What information will be shared?

Information about:

- your personal characteristics
- your medical history,
- your mental or physical condition,
- treatment and services you receive, and
- your social service information (including CalFresh, General Relief, CalWorks, Cash Assistance Program for Immigrants, Medi-Cal, and other public benefits that you may apply for).

I am in a justice-involved diversion or re-entry program. What information will you share with my probation officer?

- The only information shared with your probation officer would be your name/identifying information and the date of when you started receiving services.

What form will information be shared in?

- Oral

New Universal Consent Forms cont…

- Written
- Electronic

What do I authorize you to do with my information?

- To see if you are eligible for programs or resources
- To enroll you in programs
- To coordinate your care and treatment
- To communicate and work with your other providers
- To connect you with social services
- To receive payment for services we provide
- To improve and evaluate our programs
- For other County program activities

Certain types of health information are more sensitive. You can also allow us to share the following information:

- Information from health care providers about your mental health diagnosis or treatment that is protected under Welfare and Institutions Code § 5328 (excluding psychotherapy notes)
- Information about HIV/AIDS test results
- Information from Substance Use Disorder treatment programs (includes substance use disorder diagnoses and medications, inpatient stays and outpatient visits or residential treatment, provider names and contact information, and names of the treatment programs) that is protected under 42 C.F.R. Part 2 or State law.

If you do not agree to share sensitive information, information may not be available to the CHIP providers and organizations that work with you. Therefore, your participation in CHIP may be limited and in certain cases, you might not receive care coordination services. If you do not have any information in one or more of the categories above, you should check the box anyway, to ensure that your health information may be shared without restrictions.

You may ask for a list of all groups that have received your substance use disorder information.

When does this Authorization Form expire?

- For five years, except that this Authorization will expire for Whole Person Care on December 31, 2021 or the upon the end date of the program, if extended.
- If the Whole Person Care authorization expires, your information will continue to be shared among and between other CHIP programs that you are eligible for or that you participate in.

COMPANION TO THE AUTHORIZATION FOR THE USE
AND DISCLOSURE OF HEALTH AND SOCIAL SERVICE INFORMATION

How do I change or cancel this Authorization Form?

- You can change or cancel this authorization to share your information at any time.
- Notify your care team member that you want to change or cancel this authorization, or call 844-804-5200.
- A new Authorization Form or revocation form will be completed and signed by you to either change or cancel your information sharing.
- Should you wish to change or cancel your information sharing, the cancellation will not apply to information shared prior to receiving the updated Authorization or cancellation.

When does my cancellation take effect?

- The cancellation takes effect after we receive the revocation form.

What else is important for me to understand?

- Laws allow health care providers to share your health information for certain purposes without your consent. They can share information to:
  - Treat you
  - Get paid
  - Operate programs.

  This Authorization does not change the information that may be shared under those laws.
- You may ask us to NOT share some of your sensitive information. You can limit sharing with certain groups. CHIP may not be able to comply with all of your requests.
- When we share your information, it may be re-shared with others.
  - Federal or California privacy laws may not apply to data once it is re-shared.
- Your ability to receive medical services, treatment, or public social services does not depend upon whether you sign the Authorization. If you do not sign the Authorization, CHIP may not be able to share data to coordinate your services, and you may not be able to participate in certain CHIP.
- You have the right to:
  - Get a copy of your health and social services information that is shared through this consent
  - Refuse to sign this authorization form
  - Receive a copy of this authorization form

By signing the Authorization Form, you allow us to receive, use, and share your information as described above.

COMPANION TO THE AUTHORIZATION FOR THE USE
AND DISCLOSURE OF HEALTH AND SOCIAL SERVICE INFORMATION

Attachment A

CBEST Participant Organizations
Catalyst Foundation
Tarzana Treatment Center
Volunteers of America
St. Joseph's Center
Special Services for Groups
PATH and Lutheran Social Services

Other Organizations with Whom Data May be Shared
U.S. Social Security Administration Disability Determination Services
U.S. Veteran's Administration
California Department of Health Care Services
California Department of Public Social Services
Centers for Medicare and Medicaid Services
LA Homeless Services Authority
LA County Department of Mental Health
LA County Department of Public Health
LA County Department of Children and Family Services
LA County Department of Health Services
LA County Department of Public Social Services
LA Cash Assistance for Immigrants Program (CAPI)
LA County Department of Military and Veterans Affairs

New Universal Consent Forms cont…

AUTHORIZATION FOR THE USE AND DISCLOSURE OF HEALTH AND SOCIAL SERVICE INFORMATION

Client Name: _____ Date of Birth: _____
CHAMP Client ID: _____

The County of Los Angeles (County) Department of Health Services (DHS) operates a social services and health information exchange (SSHIE) to allow my information to be shared among and between partners in the County's Community Health and Integrated Programs (CHIP).

CHIP helps people get resources and social services that can improve their health. It coordinates health-care related assistance and social services support. CHIP includes:

- Whole Person Care Los Angeles
- Housing For Health
- Office of Diversion and Re-entry
- Countywide Benefits Entitlement Services Team (CBEST)
- Correctional Health Services – Care Transitions Unit

Many types of organizations work with CHIP, some as subcontractors, including:

- Health care providers
- Behavioral health providers
- Social services providers
- Health plans
- Housing providers
- Organizations involved with the justice system
- Legal providers
- Community organizations

These organizations provide services to participants in CHIP and need to share my health and social services information to:

- See if I am eligible for County programs
- See if I am eligible for other resources
- Coordinate my care
- Communicate with my treating providers and organizations
- Connect me to social service providers
- Provide me with services
- Receive payment for services
- Program improvement and evaluation activities
- For other County program activities

By signing my name below, I agree that my current, past, and future treating providers and organizations, and California Department of Public Social Services may disclose my health

AUTHORIZATION FOR THE USE AND DISCLOSURE OF HEALTH AND SOCIAL SERVICE INFORMATION

information, records, social services information, and other data to DHS SSHIE for CHIP and that such data may be shared among and between the programs within CHIP. I also agree that the DHS SSHIE for CHIP may disclose this information to my current, past, and future treating providers, including CHIP partners and subcontractors, and other organizations that work with CHIP, which are listed in Attachment A. for the purposes described above.

- I authorize my health and social service information to be shared through any health information exchange operated by or with participation from the County. A health information exchange is an electronic system that allows organizations to share information.
- Information that may be shared will include information about:
  - my personal characteristics
  - my medical history, mental or physical condition,
  - my social service information (including CalFresh, General Relief, CalWorks, Cash Assistance Program for Immigrants, Medi-Cal, and other public benefits that I may apply for), and
  - treatment and services I receive.
- I understand that this Authorization will apply to data from all services I receive from CHIP providers and partners and any data received by the DHS SSHIE.

I specifically authorize my current, past, and future treating providers and organizations and CHIP to share the following information (*check as appropriate*):

☐ Information from health care providers about my mental health diagnosis or treatment that is protected under Welfare and Institutions Code § 5328 _____ (*initial*) (excluding psychotherapy notes)

☐ Information about my HIV/AIDS test results _____ (*initial*)

☐ Information from substance use disorder treatment programs (includes substance use disorder diagnoses and medications, inpatient stays and outpatient visits or residential treatment, provider names and contact information, and names of the treatment programs) that is protected under 42 C.F.R. Part 2 or State law _____ (*initial*)

I may ask for a list of providers and organizations that have received my substance use disorder information.

I understand:

- This Authorization will be valid for five years, except that this Authorization will expire for Whole Person Care on December 31, 2021 or the upon the end date of the program, if extended. If the Whole Person Care authorization expires, my information will continue to be shared among and between other CHIP programs that I am eligible for or that I participate in.

New Universal Consent Forms cont…

AUTHORIZATION FOR THE USE AND DISCLOSURE OF HEALTH AND SOCIAL SERVICE INFORMATION

- I have the right to cancel or change this Authorization at any time. I can start this process by talking to Care Team Member or calling 844-804-5200. At that time, I will either cancel my Authorization or complete a new Authorization to reflect the change(s) to the sensitive information that I want to share. If I limit my information sharing, my sensitive information will not be shared with partnering providers or organizations from that date forward. Any sensitive information previously shared with current or past treating providers cannot be recalled. Should I elect not to share any sensitive information, I may receive limited care coordination services.
- State and Federal laws already allow health care organizations to share my health information to treat me, obtain payment, and run their operations. I understand that this Authorization does not change the information that can be shared under these laws.
- When my information is shared, there is a chance it will be re-shared with others. Federal law or California privacy law may not protect the re-sharing of my information.
- My ability to receive medical services, treatment, or public social services does not depend upon whether I sign this Authorization. If I choose not to sign this Authorization, CHIP may not be able to share data to coordinate the services I receive, and I may not be able to participate in CHIP.
- I have the right to:
  - Inspect or obtain a copy of my health information and social services information that is shared by this Authorization
  - Refuse to sign this Authorization
  - Receive a copy of this Authorization

I have read this authorization or a CHIP Representative or Care Team Member has read it to me. I authorize the use and sharing of my health and social services information as described above.

_____ _____
Client Signature Date

If this Authorization is signed by a person other than the client, please indicate the relationship:

_____
Relationship to Client

_____ _____
Name Date

AUTHORIZATION FOR THE USE AND DISCLOSURE OF HEALTH AND SOCIAL SERVICE INFORMATION

Attachment A
Non-Treating Providers (for Payment, Benefits Advocacy, etc.)

CBEST Participant Organizations
Catalyst Foundation
Tarzana Treatment Center
Volunteers of America
St. Joseph's Center
Special Services for Groups
PATH and Lutheran Social Services

Other Organizations with Whom Data May be Shared
U.S. Social Security Administration Disability Determination Services
U.S. Veteran's Administration
California Department of Health Care Services
California Department of Public Social Services
Centers for Medicare and Medicaid Services
LA Homeless Services Authority
LA County Department of Mental Health
LA County Department of Public Health
LA County Department of Children and Family Services
LA County Department of Health Services
LA County Department of Public Social Services
LA County Department of Military and Veterans Affair
LA Cash Assistance for Immigrants Program (CAPI)

AUTHORIZATION FOR THE USE AND DISCLOSURE OF HEALTH AND SOCIAL SERVICE INFORMATION

I revoke the authorization submitted to the DHS HIE as of _____ (DATE). This revocation does not affect any disclosures made prior to receiving this revocation. This authorization does not change the information that may be shared under State or federal laws.

_____ _____
Client Signature Date

If this Revocation is signed by a person other than the client, please indicate the relationship:

_____
Relationship to Client

_____ _____
Name Date

HOUSING FOR HEALTH

The Recuperative Care Experience

Katina Holliday, FNP, Chief of Nursing

Serenity Recuperative Care

Health Services
LOS ANGELES COUNTY

The Recuperative Care Experience…

- What clients have to look forward to when arriving the Interim Housing (IH) with Serenity Recuperative Care.
- Support Services Provided while in IH Recuperative.
- Supportive Staff within the Recuperative Care Setting.
- Description of what the IH Recuperative sites look like.

A look Inside Serenity Recuperative Care…

A look Inside Serenity Recuperative Care cont…

HOUSING FOR HEALTH

Know the Individual-Sample Case Discussion

Savanah Walseth, HFH Program Manager

Health Services
LOS ANGELES COUNTY

Tom
64 years old
-Living on the streets of Whittier
-Visits ER/hospitals regularly
-Currently in local private hospital

History of dementia, needs a sitter for fall risk (unsteady gait), oriented to name only- (according to PT notes)

Terry

34 years old

-Living in car in Van Nuys

-Estranged from family

-Brought in by local Law Enforcement

-Currently on 5150 hold

Came into the local private hospital for a persistent cough/fever

Q & A…

Contact Information

DHS Interim Housing Program

Email: InterimHousing@dhs.lacounty.gov

Main Line: (323) 274-3300

Fax Line: (213) 895-0100