

Client Name (First, Last):

LOS >30 days: Yes No DOB:

## HCF-DHS REFERRAL FORM

### Screening Tool for Referral from Health Care Facilities: SINGLE ADULT

This HCF-DHS Referral Form must be completed for each patient who is admitted to a healthcare facility (HCF) or a long-term care facility (LTCF) and is being referred to the DHS Single Adult Shelter or Street System. Completion of this form for each patient will help Department of Homeless Services (DHS) to determine if:

- (1) The patient is medically appropriate to reside in a single adult DHS shelter or Safe Haven facility; and
- (2) All efforts have been made first to discharge the patient to a non-shelter setting.

Shelters for single adults are congregate settings with open dormitory-style rooms and do not provide nursing services; there are **no medical or respite shelters in the New York City DHS Shelter System.**

- For detailed guidance on this form, including a brief description of DHS and coordination of care guidance, see the *Referral from Healthcare Facilities to DHS Single Adult Facilities*, (hereafter referred to as the procedure) found at: <https://www1.nyc.gov/site/dhs/shelter/singleadults/single-adults-hospital.page>.
- Electronically completed forms are best practice, and DHS will review all received forms sent via email.
- Determinations regarding referrals or requests for more information will be communicated via email.
- If a homeless patient leaves against medical advice, please email [HCF-DHSreferral@dhs.nyc.gov](mailto:HCF-DHSreferral@dhs.nyc.gov).
- This is a PDF fillable form and must be **electronically completed and submitted**. Forms that have been handwritten and/or faxed will not be accepted.

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#### To use this form:

- 1- Call the DHS Referral Line at 212-361-5590 to determine if the patient is a new or current DHS client.
  - a. If the patient is a current DHS client, the HCF will request the name of the client's assigned DHS site and the email address to which the referral form should be sent. The shelter director of the patient's assigned site.
  - b. If the patient is new to the DHS system or has been out of shelter for over 12 months, email the form to:
    1. [DHS-HCFreferral@dhs.nyc.gov](mailto:DHS-HCFreferral@dhs.nyc.gov) for men, and
    2. [HCF-Referral@helpusa.org](mailto:HCF-Referral@helpusa.org) for women.
- 2- Complete the form and email it to the appropriate email address.
- 3- After the form has been sent via email, the DHS site or Office of the Medical Director will respond with a determination within 1 business day for inpatient stays less than 30 days and 2 business days for inpatient stays of 30 days or more.

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**Absolute Exclusion Criteria for DHS single adult shelter or safe haven**

If the patient has one or more of the health conditions, limitations of independent activities, or functional needs listed below, they are medically inappropriate for DHS single adult shelter or Safe Haven

<ul style="list-style-type: none"> <li>• Inability to care for self and independently manage activities of daily living; use the ADL Assessment Form included on the Referral Form. An ADL score &lt;12 indicates medical inappropriateness for shelter. The ADL Assessment Form must be completed by a clinician on the patient’s team;</li> <li>• Lack of decisional capacity;</li> <li>• Need for home care or visiting nurse services beyond wound care or IM/IV medication administration and beyond 2 weeks;</li> <li>• Severe immunosuppression (chemotherapy, end-stage AIDS, post-transplant, with an Absolute Neutrophil Count (ANC) &lt;500mL);</li> <li>• Major dementia with cognitive deficits (MMSE &lt;25);</li> <li>• Peritoneal dialysis;</li> <li>• Inability to make needs known or follow commands;</li> <li>• Unresolved delirium;</li> </ul>	<ul style="list-style-type: none"> <li>• Inability to independently manage chronic illnesses or medication administration, schedule, and reminders, including inability to self-administer insulin;</li> <li>• Inability to independently manage urinary catheters;</li> <li>• Inability to manage urinary or bowel incontinence or explosive diarrhea;</li> <li>• Oxygen-dependence requiring an oxygen tank/cylinder of any size, containing liquid or compressed oxygen (oxygen concentrators are allowed);</li> <li>• Cranial Halo Devices or stabilizing protective gear worn continuously;</li> <li>• Poses imminent risk of physical harm to themselves or others;</li> <li>• Inability to: understand spoken, signed, visual, or tactile language with or without an interpreter; or</li> <li>• On a ventilator.</li> </ul>
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**If the patient has any of the health conditions, limitations of activities, or functional needs listed on this page **STOP**, the patient is medically inappropriate for a DHS shelter or Safe Haven and should not be sent to DHS. For more information on alternative housing solutions, please go to: <https://www1.nyc.gov/site/hra/help/homelessness-prevention.page>.**

**Relative Exclusion Criteria for DHS single adult shelter or Safe Haven**

If one or more of the following apply to the patient, the HCF/LTCF may be contacted for additional information by the DHS Office of the Medical Director or relevant site.

<ul style="list-style-type: none"> <li>• Requires infusion pumps/ PICC lines</li> </ul>	<ul style="list-style-type: none"> <li>• Intra-muscular or intra-venous medication administration via nurse- no more than twice per day, must be prearranged by HCF and limited to no more than 2 weeks</li> </ul>
<ul style="list-style-type: none"> <li>• Colostomy bag</li> </ul>	
<ul style="list-style-type: none"> <li>• Tracheostomy/ feeding tube</li> </ul>	

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Reviewer name:	CARES number:
Gender:	SSN:
DOB:	HCF of origin:
Date and time review completed:	Destination shelter/ Safe Haven:
Does the client appear to need a reasonable accommodation?	Has the HCF requested a reasonable accommodation?
Status of referral:	Additional information needed:
If follow up referral, number of requests for information for this client:	Date/ time additional information requested:
Person information was requested from:	
If patient was medically inappropriate or more information needed, reason why:	
<b>POST ARRIVAL AT DHS SITE</b>	
Date patient arrived at shelter:	
Arrived,	
in worse state than described in referral	despite determination of medical inappropriateness
medically inappropriate and was transported back to healthcare facility	within 24 hour period of referral being sent
at shelter outside of the hours between 9:00am and 3:00pm	medically inappropriate and was kept in shelter until situation resolved

**Healthcare facility staff please begin form here:**

<b>Name of healthcare facility:</b>	<b>Type of HCF:</b>
Name of primary person completing this form:	First alternate Email address:
Title:	Telephone/beeper:
Email Address:	Second Alternate Email address:
Telephone/beeper:	Telephone/beeper:
<b>Date this form was completed:</b>	<b>Date of Admission:</b>
<30 day length of stay    Yes        No	<b>Expected Date of Discharge:</b>

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## Section 1. Patient Demographic and Healthcare Facility Information

1.1	Alias(es)	CARES # (if known)
	Date of Birth:	Facility MRN:
	Insurance type:	Insurance #:
	Ethnicity:	Social Security #:
	Race:	Other specify:
	Gender:	Other specify:
	Patient agrees to be placed in shelter if found medically appropriate: Yes No Not Yet	

To ensure that all DHS shelter/Safe Haven referrals are independently able to complete all activities of daily living, indicate the DHS ADL assessment (page 5) score below.

**DHS ADL Assessment Score:**

If the patient scores less than 12 on the DHS ADL Assessment Form, they are inappropriate for shelter.

1.2	Healthcare facility name:	
	Department or Service:	
	Telephone number:	
	Inpatient Physician Name:	Social Worker Name:
	Telephone:	Telephone:
	Email:	Email:
1.3	Primary Care Physician Name:	Care Coordinator Name:
	Telephone:	Telephone:
	Email:	Email:

- 1) Call the DHS Referral Line at 212-361-5590 to inquire if patient is known to DHS. You will be given the pertinent email address where the referral should be sent. If there is no answer, please leave a voicemail and someone will return your call as soon as possible.
- 2) If the patient has been in shelter in the last 12 months, go to Section 3 (skip Section 2).
- 3) If the patient is new to the DHS System or has not been in shelter in the past 12 months, go to Section 2.

1.3	Is patient new to DHS or have they not been in shelter within the past 12 months? YES NO
	If the patient has been in a Single adult shelter in the past 12 months, please identify the patient's shelter of record:

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**DHS ADL Assessment for Institutional Referrals**

To be completed by healthcare facility staff only

<b>Patient Name:</b>		<b>Patient date of birth:</b>	
<b>Name and title of the person completing this assessment:</b>			<b>Date:</b>
<b>Scope</b>	<b>The patient is able to...</b>	<b>Yes (1)</b>	<b>No (0)</b>
BATHING	Bathe self independently. May use devices such as shower chair and/or grab bars.		
DRESSING	Independently retrieve all clothing, dress, and undress, including shoes and outer garments.		
GROOMING	Groom self independently including shaving, brushing teeth and hair, and other common grooming activities.		
TOILETING	Successfully complete toileting independently including transferring and without supervision, preventing soiling of clothing and using toilet paper. May use raised toilet and/or grab bars.		
BOWELS	Manage bowels, catheter, colostomy bag, or diapers independently and without leaks.		
BLADDER	Control bladder functions without assistance, can include use of diapers to control leaking or minimal incontinence.		
TRANSFERRING	Independently transfer from wheelchair to bed and vice versa. May use elevated bed.		
FEEDING	Feed self independently, including for example carrying food tray, opening common food and drink containers, and cutting up own food.		
MOBILITY	Independently ambulate or use a cane, walker, or propel a manual or motorized wheelchair.		
COMMUNICATION	Communicate through spoken, signed, visual, or tactile language with or without an interpreter.		
COGNITION	Understand directions and follow commands, and make needs known.		
SELF-MANAGEMENT	Manage key responsibilities associated with independent living including medications and chronic illness(es).		
Total points from answers. If score is <12, patient is not appropriate for shelter.		<b>Total Score:</b>	

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## Section 2. Housing History for New Clients of the Single Adult Shelter System

Prior residence, before current admission			
The HCF/LTCF must make all efforts to place patient in permanent housing before making a referral to DHS.			
2.1	<input type="checkbox"/> Home: rental/own/lease holder/ lived with partner or spouse	Residential facility: <input type="checkbox"/> Adult Home <input type="checkbox"/> Skilled nursing facility <input type="checkbox"/> Residential drug treatment facility <input type="checkbox"/> OMH residential mental health facility <input type="checkbox"/> Rehabilitation center <input type="checkbox"/> Assisted living, other:	<input type="checkbox"/> State psychiatric hospital, name:
	<input type="checkbox"/> Single Room Occupancy (SRO)		<input type="checkbox"/> Prison, name:
	<input type="checkbox"/> Aged out of foster care		<input type="checkbox"/> Jail, name:
	<input type="checkbox"/> Lived in friend's or relative's home		<input type="checkbox"/> Other, Specify:
2.2	Was the patient street homeless?		Yes      No
2.3	If street homeless, length of stay in streets in past year if known/applicable:		<input type="checkbox"/> Unknown
	Usual locations, if known/applicable:		<input type="checkbox"/> Unknown
2.4	Was the patient's prior living situation in another city/state/country?		Yes      No
	- If yes, specify city and state:		
	- If yes, was patient staying in a homeless shelter?		Yes      No
2.5	Length of stay at last location		
	What has changed at last residence to prevent patient from returning?		
2.6	For those who meet Adult Protective Services (APS) ( <a href="https://www1.nyc.gov/assets/hra/downloads/pdf/services/aps/APS_BROCHURE.pdf">https://www1.nyc.gov/assets/hra/downloads/pdf/services/aps/APS_BROCHURE.pdf</a> ), is the patient under the care of APS?		Yes      No
2.7	<b>Reasons patient is homeless:</b>		
	<input type="checkbox"/> Lost employment	<input type="checkbox"/> Evicted/ other reasons	
	<input type="checkbox"/> Divorce/ separation	<input type="checkbox"/> Evicted/ did not pay rent	
	<input type="checkbox"/> Domestic violence	<input type="checkbox"/> Aged out of foster care	
	<input type="checkbox"/> Recently released from jail, prison, or other criminal justice institution	<input type="checkbox"/> Other, specify:	

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**Housing applications:** As applicable, detail the efforts that were made to assist the patient in securing a return home or another non-shelter setting based on housing and clinical history. Please provide outcomes and list all efforts: attempted, reason failed, or ineligible.

2.7	Potential Housing	Attempted: date	Reason Failed	Not eligible	N/A
	Relative's or friend's home				
	Return to own home				
	Adult home				
	Skilled nursing facility				
	Sub-acute unit				
	Rehabilitation center				
	Residential drug treatment facility				
	OMH residential mental health facility				
	Assisted living, other:				
	SRO				
	Applied for rental assistance				
	Applied for other subsidies/ rental assistance with HRA				
	HASA services (if eligible)				
	Voluntary diversion to residence outside NYC				
	Other, specify:				

Please indicate reasons why the patient is ineligible for all non-shelter housing options:

**Please include housing applications submitted and any available documentation thereof.  
An HRA 2010e application for supportive housing should ideally be made prior to discharge for potentially eligible patients.**

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**Section 3. Clinical Information**

Reason for admission: *Indicate the principal reason for admission. If reason is not listed, please specify other reason for admission in text box labelled "Specify other reason for admission."*

3.1	<input type="checkbox"/> Chronic Disease	<input type="checkbox"/> Accident or injury	<input type="checkbox"/> Psychiatric distress
	<input type="checkbox"/> Substance use	<input type="checkbox"/> Alcohol intoxication	<input type="checkbox"/> Suicidal ideation
	<input type="checkbox"/> Homicidal ideation	<input type="checkbox"/> Suicide attempt	<input type="checkbox"/> Acute illness
	<input type="checkbox"/> Other, specify:		

3.2	<b>Was the patient admitted for violent or threatening behavior?</b>	Yes	No
	<u>If yes:</u>		
	1. Was the patient compliant with medications while in the healthcare facility?	Yes	No
	2. Does the patient have insight related to their mental illness?	Yes	No
	3. Does the patient have insight into their need to be compliant with medications upon release?	Yes	No
	4. Date of last known episode of violence:		
	5. Date of last emergency injection (if applicable):		

3.3	Does the patient have a known history of arson?	Yes	No
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3.4	In past 12 months prior to this admission, self-reported number of:
	<b>Hospital stays:</b> None <input type="checkbox"/> 1 or more, approximate number:
	<b>ED visits:</b> None <input type="checkbox"/> 1 or more, approximate number:

3.5	<b>DISCHARGE DIAGNOSES: Indicate all medical and mental health diagnoses:</b>		
	<b>MEDICAL</b>		
	Arthritis or other joint disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	Cancer	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	Type of cancer:	ANC #:	
	Chronic kidney/renal disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	On dialysis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	Chronic liver disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	Cirrhosis	Yes <input type="checkbox"/>	No <input type="checkbox"/>



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Hepatitis B	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Hepatitis C	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Chronic pulmonary disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>
COPD	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Emphysema	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Asthma	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Chronic bronchitis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Cognition (not related to a Developmental Disability, specify):		
Delirium	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Dementia (any form)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
MMSE score:		
Diabetes- insulin dependent	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Able to self-administer insulin?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Head injury or trauma	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Heart Disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Heart failure	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Class IV:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
HIV/AIDS	Yes <input type="checkbox"/>	No <input type="checkbox"/>
CD4 count		
HASA referred	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Hypertension	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Immuno-suppressed	Yes <input type="checkbox"/>	No <input type="checkbox"/>
ANC score:		
Incontinence (urinary or bowel)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Recent surgery	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Type of surgery:		
Seizure disorder/ epilepsy	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>DEVELOPMENTAL DISABILITY</b>		
Does the patient have a diagnosis of, or if there reason to believe they have a diagnosis of a developmental disability (or show signs of):		
Autism Spectrum Disorder	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Cerebral Palsy	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Intellectual disability (formerly known as Mental Retardation)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Neurological Impairment	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Seizure Disorder (before age 22)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Any diagnosis that manifests similarly to Intellectual Disability	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>BEHAVIORAL HEALTH</b>		

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<b>Mental health:</b>		
Anxiety disorder	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Bipolar disorder	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Depression	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Obsessive-Compulsive Disorder	Yes <input type="checkbox"/>	No <input type="checkbox"/>
PTSD	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Schizoaffective Disorder	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Schizophrenia	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>Substance and Alcohol use:</b>		
Substance use	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Specify drug:		
History of non-fatal overdose	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Date <i>if known</i> :		
Other conditions not listed above:		

**If a cognitive impairment is indicated, please send a complete MMSE with this Referral Form.**

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### Section 4. Functional Status

For patients with a disabling condition due to a medical condition or disability, please attach a completed DHS Reasonable Accommodation Request Form (<https://www1.nyc.gov/assets/dhs/downloads/pdf/client-accom-request-form.pdf>) when this Referral Form is submitted. For example, but not limited to: gastrostomy tube, tracheostomy/feeding tube, requires infusion pumps or picc lines, colostomy bag, needs wound care or nursing visits, or uses a wheelchair, walker, cane or crutches, CPAP or BiPAP/ BPAP machine, or oxygen concentrator.

For additional guidance, see the *Process for Referral of Single Adults from Healthcare Facilities to the DHS Single Adult Shelter System*.

Please attach PRI if patient is being referred from a Long Term Care Facility and those hospitalized for > 2 months.

4.1 Health conditions, limitations of independent activities, and functional needs:			
Urinary catheter	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
Urostomy bag	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
If yes to any diagnosis or possibility of diagnosis to developmental disability listed in section 3.5:			
Did any of the following codes appear in eMedNY/ePACES: 44,45,46,49, and 95?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Was OPWDD contacted?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Indicate which codes appear and what the outcome of the conversation was with OPWDD:			
Gastrostomy tube	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
Tracheostomy/feeding tube	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
Intra-muscular or intra-venous medication administration via nurse- no more than 2 per day, must be prearranged by HCF and limited to no more than 2 weeks	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
Requires infusion pumps/ PICC lines	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
Colostomy bag	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
Unable to walk more than a few feet alone	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
History of accidents or leaks	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
History of falls	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
Wound care	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
Number of dressing changes per day: _____			N/A <input type="checkbox"/>
Able to manage wound dressing alone	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
Nursing Service	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
Estimated number of visits per day:			
Describe function:			
Arranged?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>

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Please arrange nursing visits for first thing in the morning before shelter clients have left the premises.			
Contact Name:		Phone number/Email:	
Estimated number of weeks of VNS required:			
Can the patient communicate via any method (interpreter, spoke, written, tactile, etc.)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
<b>4.2 Durable Medical Equipment:</b>			
Wheelchair	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Walker	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Cane or crutches	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
CPAP or BiPAP machine	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Oxygen concentrator	Yes <input type="checkbox"/>	No <input type="checkbox"/>	

**Medications list:** Please list all discharge medications for the patient. If unable to include medication list here, please attach a medications list *only* as an attachment to this form.

4.3	
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**Comments:** Please include any relevant information that DHS site staff or OMD should be aware of regarding the patient, reasons for admission, discharge, or care coordination.

4.4	
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## Section 5. Discharge Plans

- Please indicate below if follow-up plans are still being arranged and email to the relevant site all follow up plans as early as possible and at the latest, by the day of discharge.
- Referrals must include planned follow-up care including a primary care physician appointment.
- If the client is on AOT or an ACT team, please submit a Reasonable Accommodation form for a location-based placement.

<b>5.1 Follow-up plan:</b>					
Are follow-up care appointments still being arranged?			Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
Are follow-up plans attached to this form?			Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
Medical appointment	Date	Time	Location		N/A <input type="checkbox"/>
Contact Name:		Phone number/Email:			
Mental health appointment	Date	Time	Location		N/A <input type="checkbox"/>
Contact Name:		Phone number/Email:			
Substance use services	Date	Time	Location		N/A <input type="checkbox"/>
Contact Name:		Phone number/Email:			
Surgical follow-up	Date	Time	Location		N/A <input type="checkbox"/>
Contact Name:		Phone number/Email:			
Physical therapy initial appointment	Date	Time	Location		N/A <input type="checkbox"/>
Contact Name:		Phone number/Email:			
Other appointment (1):	Date	Time	Location		N/A <input type="checkbox"/>
Contact Name:		Phone number/Email:			
Other appointment (2):	Date	Time	Location		N/A <input type="checkbox"/>
Contact Name:		Phone number/Email:			
Application made for Health Home			Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
Health Home care coordinator	Name:				N/A <input type="checkbox"/>
Telephone:			Email:		
AOT order application done			Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
If yes, was final court order and treatment plan received?				Yes <input type="checkbox"/>	No <input type="checkbox"/>
If no, does the patient not meet criteria? Specify:					
Is the patient on ACT team?			Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
Name of ACT team:			Borough of ACT team:		
ACT team contact name and phone number/email:					

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**Section 6. Treatment Team Approval**

In the opinion of the clinical treatment team, the patient is independent (does not require support or assistance) in activities of daily living as detailed in the DHS ADL Assessment for Institutional Referrals on page 5, and the patient:

- Will be able to function in shelter in a congregate setting and without home care or long term nursing support; and
- Has no health, mental, or emotional concerns that may make them a danger to themselves or others in a shelter setting.

**If one or both of the above statements are false, the patient is inappropriate for shelter.**

We, the treatment team identified below, hereby attest to the truth of the above statements, and that everything included in this HCF-DHS Referral Form is a true and accurate representation of the health conditions, limitations of independent activities, and functional needs of the patient. We explored non-shelter housing options to the best of our abilities and confirm that no viable and safe alternatives to shelter were found prior to making this referral to DHS.

**Treating Provider**

Name	Title
Telephone	Email

**Social Worker**

Name	Title
Telephone	Email

**Member of treatment team**

Name	Title
Telephone	Email