COVID-19 Alternate Housing Referral Form

This form is for low-income individuals/families needing shelter options to safely isolate/quarantine. Complete a referral form for each client needing Alternate Housing**.** Submit completed forms to:

COVID-19HomelessResponse@santacruzcounty.us

For persons experiencing homelessness, use the Covid-19 Shelter Referral Form.

Date and Time of Referral: _____

Referred by: _____ _____ _____

Name **Organization** **Phone Number/Ext.**

Client Name: _____ **DOB:** _____ **Age:** _____

Spoken Language: _____

Client's Priority Level

☐ AH 1 - Persons that are **confirmed COVID-19 positive**

Date of positive test _____

Date of symptoms onset _____

☐ AH 2 - Persons that are **presumed COVID-19 positive** (Client has COVID-19 symptoms **and** has been in known contact with COVID-19 positive individuals)

Date of contact with COVID-19 positive person_____

Date of symptoms onset _____

☐ AH 3 - Persons who public health would advise to self-quarantine because either of the following (check only one):

☐ Client has COVID-19 symptoms

Date of symptoms onset _____

☐ Client has had significant contact with COVID-19 positive individuals

Date of contact with COVID-19 positive person_____

Client Location - Where can client be found if they need to be transported to an Alternate Housing location?

Client Phone: _____ **Client Email:** _____

Someone that can relay message to client: _____ _____

Name **Phone**

<u>Medical Condition/Needs</u>

Summary of medical condition and issues:

Current Medications:

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Physical Disabilities: _____

Communication Issues (hearing, vision): _____ **TBI or Cognitive Issues:** _____

Does Client require ADA unit? ☐ Yes ☐ No **Does Client smoke?** ☐ Yes ☐ No

Known allergies (medication, food, other): _____

Assistive Devices: ☐ Yes: _____ ☐ No **Requires Insulin:** ☐ Yes ☐ No

Self Care: ☐ Yes ☐ No **Incontinent?** ☐ Yes ☐ No **Special Med. Requirements:**_____

Mental Health Diagnosis/Concerns: ☐ Yes: _____ ☐ No

Known Substance Abuse Issues: ☐ Yes: _____ ☐ No

Pet? ☐ Yes ☐ No **If yes, type:** _____

Care Team/Support

Primary Care Physician: _____ **Phone Number:** _____

Social Worker: _____ **Phone Number:** _____

Case Manager: _____ **Phone Number:** _____

Therapist/Psychiatrist: _____ **Phone Number:** _____

Treatment Program: _____ **Phone Number:** _____

Insurance (if known): _____

Additional Information – Use this space to write anything else pertinent to know for this referral:

Please list any people who the client could share a hotel room. If additional space needed, include in e-mail with referral. <u>Complete a referral form for each client needing Alternate Housing.</u>

Name: _____**Age:** _____ **Relationship:**_____ **Referral submitted** ☐
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