COVID-19 Shelter Referral Form

This form is for:

1. Individuals experiencing homelessness that need either congregate or non-congregate (motel) shelter
2. Low-income individuals/families needing shelter options to safely isolate/quarantine (Alternate Housing). Referrals will only be accepted from hospitals, safety-net clinics and Public Health for this population.

For questions please e-mail: COVID-19HomelessResponse@santacruzcounty.us

Date and Time of Referral: _____

Referred by: _____ _____ _____
Name **Organization/Shelter** **Phone Number**

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

Spoken Language: _____ **Date of Symptom Onset (if applicable):** _____

Client's Priority Level (Please note, priority 4 persons are accepted *only* as space/need allows)**:**

☐ PRIORITY 1 - Persons experiencing homelessness that are **confirmed COVID-19 positive**
Date of positive test _____
Date of symptoms onset _____

☐ PRIORITY 2 - Persons experiencing homelessness 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_____

☐ PRIORITY 3 - Persons experiencing homelessness who public health would advise to self-quarantine because either of the following (check only one):
☐ Client has COVID-19 symptoms
☐ Client has had significant contact with COVID-19 positive individuals
Date of contact with COVID-19 positive person_____
Date of symptoms onset _____

☐ PRIORITY 4 - Persons experiencing homelessness that are **elderly (65+ years old) or medically vulnerable**. Explain client's medical vulnerability:

_____

☐ PRIORITY 5 - All other homeless individuals that do not meet the criteria required for priorities 1-4.

☐ ALTERNATE HOUSING – Low-income individuals/families that are not homeless and are in need of shelter to safely isolate/quarantine (complete all pages of referral)

Client Location - Where can client be found so that they can be transported to a Shelter in Place location? Please be as descriptive as possible, use back of form if additional space needed:

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

Someone that can relay message to client: _____ _____
Name **Phone**

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For Priority 4 and ALTERNATE HOUSING clients, please list any people who the client could share a hotel room. Use back of form if additional space needed.

Name: _____Age: _____ Relationship:_____ Have/will have referral ☐

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Medical Condition/Needs

Summary of medical condition and issues:

_____

_____

Physical Disabilities: _____ **Chronic Health Issues:** _____

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

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

Prefer North or South County? ☐ North ☐ South ☐ No preference

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:

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Alternate Housing Referral

Complete to verify client need

This form must be attached to pages one and two of the COVID-19 Shelter Referral Form

What is Alternate Housing?

In Santa Cruz County, Alternate Housing shelter is not for homeless, but rather for low-income patients who are COVID-19 positive, do not need hospitalization and cannot isolate themselves during recovery in order to prevent the spread of the virus. Alternate Housing may also be provided to low-income patients who have been directed to quarantine due to a suspected exposure to COVID-19, or to family members/housemates allowing the patient to isolate or quarantine at home. Patients are referred through County Public Health, by safety-net clinics or hospitals. Placements will be made at local motels/hotels in either North or South County where capacity is available.

Alternate Housing Assessment. Check all that apply. Referring source may be asked to verify information.

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

  Date of contact with COVID-19 positive person: _____

  Date of symptoms onset: _____
- ☐ Patient is low-income (Medi-Cal eligible, on WIC, safety-net clinic)
- ☐ Patient cannot I/Q at in a separate space in the home.
- ☐ Patient cannot I/Q with friends or family.
- ☐ Roommates or other household members cannot I/Q with friends or family.
- ☐ If patient is employed, employer cannot provide housing.
- ☐ Must be over 18 or will be accompanied by a guardian.
- ☐ Does not require medical attention unless there is a plan to provide it. Include medical plan details: