RECUPERATIVE CARE PROGRAM
Application Submission Checklist
(TO BE FAXED ALONG WITH APPLICATION)

Patient Name: ______________________________ Date: ______________

Ref. Agency: ______________________ Person making referral: ______________
Please Print

	COMPLETED FORMS
☐	Program Referral Form (to be completed by social/referring personnel)
☐	Provider Referral Form (to be completed by MD/PA/NP)
☐	Letter of Verification of Homelessness (on hospital/referring agency letterhead)
☐	Pt demographic information (Hospital Face Sheet)
☐	Medication Reconciliation Form (to be filled out by MD/PA/NP)
☐	Public Health Communicable Disease Disclosure
	MEDICAL RECORD
☐	INITIAL History and Physical Evaluation
☐	Specialty Consult Notes (orthopaedics, psychiatry, substance abuse etc. If applicable)
☐	MD progress notes detailing pt's hospital course/updated medical condition
☐	MD discharge summary with plan (follow-up appts must be noted)
☐	PT/OT clearance if pt requires assistive device for ambulation. Note: Pt must be cleared for discharge to HOME.
☐	TB/CXR results
☐	Laboratory studies (blood, imaging studies, cultures if applicable)
	UPON DISCHARGE
☐	Pt must have 30 days supply of medication (if prescribed upon discharge)
☐	Wound care supply if needed with explicit wound care instructions ("cont. wound care is not sufficient")
☐	Pt must be discharged with assistive device if needed
☐	Pt must have be discharged with appropriately fitting shoes
☐	Pt must have follow-up care plan (specialty follow-up if deemed neccessary by the provider in charge of pt's care)

Application submitted by: ______________________________
(Signature)

Please see our **"Admissions Criteria and Recuperative Guidelines"** for additional information.
For further clarification on the referral process, please contact:
Nancy Anguiano @ 213.689.2131 or 213.689.2132

The above completed forms and ancillary information should be faxed to our Recuperative Bed Control Unit at 213.624.2302. Please be sure to include this checklist.

RECUPERATIVE CARE PROGRAM
Case Manager Referral Form
(TO BE COMPLETED BY SOCIAL SERVICES)

Date and Time of Referral: ______________________ (mm/dd/yr) ______________________ (Time)

JWCH Recup Care Contact Person: ☐ D. Saupan ☐ Nancy Anguiano ☐ Other: ______________________

Ref. Agency: ______________________ Person making referral: ______________________ (Please Print) Contact#: ______________

Patient Name: ______________________________________ Re-admission Request: ☐ Yes ☐ No

DOB: ______________ SS#: ______________________ Gender: ☐ M ☐ F ☐ Other ______________

Is patient homeless? ☐ Yes ☐ No If yes, please attach verfication letter.

Usually resides at/near: ______________________ Usual source of medical care: ______________________

Substance abuse:	Past Use Y	Past Use N	Current Use Y	Current Use N	Last Used
Alcohol	☐	☐	☐	☐	________
Heroine	☐	☐	☐	☐	________
Cocaine/crack	☐	☐	☐	☐	________
Opiates	☐	☐	☐	☐	________
Benzo	☐	☐	☐	☐	________
Other	☐	☐	☐	☐	________

Is the patient:	Y	N
Sex offender?	☐	☐
Convicted of a sexual crime	☐	☐
Arsonist	☐	☐
History of assault on an officer	☐	☐
Unstable med or psychiatric conditions?	☐	☐
Require higher level of care (i.e. convalescent, skilled nursing facilty)	☐	☐

IMPORTANT, Pls Complete
(Follow-up Appts After Discharge)

Specialty	Date	Time	RM #	Contact #

PLEASE NOTE:

Patient must bring with him/her any needed medications.

We share space in facilities that do not allow drug or alcohol use. Please assure that client being referred is aware of this restriction.

Form Completed By: ______________________________
(Signature)

RECUPERATIVE CARE PROGRAM

Provider Referral Form

(TO BE COMPLETED BY **REFERRING PROVIDER**)

The Recuperative Care Program provides transitional housing, meals, case management, nursing and primary medical care to homeless individuals with acute medical conditions that would benefit from a respite from the rigors of living on the streets. The patient must be stable for discharge **TO HOME.** We are not staffed to provide any bedside assistance. We ask that the physician responsible for the care of the patient complete this form. The application and supporting materials can be faxed to us at (213) 624-2302. Please feel free to call us with any questions. We can be reached at (213) 689-2132.

Responsible Physician/Provider ______________________ Provider's contact#: ______________
Provider completing this form (PLEASE PRINT)

Patient's Name: ______________________ Patient's MR#: ______________

DOB: ______________ SSN: ______________

MEDICAL REASON for referral (**ACUTE,** time limited condition): ______________

____

____

Admit date/Intial evaluation: ______________ Any surg procedures? ______________
(Procedures)

Briefly explain HPI/ACUTE medical condition: ______________

____

____

Does patient require wound care (if so pls describe the wound, location, size) ______________

____

Wound care instructions: ______________

Are there mental/behavioural, health/substance abuse issues? ______________
How have these been addressed? Pls attach any consultant recommendations and scheduled follow-up.

____

Any other medical problems (PMH etc.)? ______________

Any special care requirements? (Special diets, infectious dz concerns, etc.): ______________

Anticipated D/C date: ______________ Arrangements for specialty follow-ups? ______________
(Pt to call/To be mailed is not acceptable)

PATIENT'S STATUS

	Y	N		Y	N	
Able to care for self:	☐	☐	Any communicable dz? (TB, MRSA, scabies etc.)	☐	☐	______ If yes, pls explain. Any tx?
Pt requires O_2?	☐	☐	Bowel & bladder continent?	☐	☐	
Ambulatory?	☐	☐	Assistive device?	☐	☐	______ Assistive device used (pls attach PT notes)
Indwelling catheter?	☐	☐	Require insulin?	☐	☐	
Can pt self admin. meds?	☐	☐	IV abx upon d/c?	☐	☐	______ If yes, which abx and length of Rx

ESTIMATED LENGTH of stay in Recup Program: ____ days ____ wks

______________________ (Signature of Referring Provider)   ______________ Date

FOR INTERNAL USE ONLY

Pt in Case Track System? ☐ Y ☐ N ______________ Red Dot: ☐ Y ☐ N
Checked By

Approved for Recup Care ☐ Y ☐ N If no, reason: ______________

Reviewed by: ______________ ______________
Provider Signature

JWCH INSTITUTE, INC.
Health & Medical Services

RECUPERATIVE CARE PROGRAM
Medication Reconciliation Form
(TO BE COMPLETED BY **REFERRING PROVIDER or RN**)

MEDICATION RECONCILIATION

(Please List Only Medications Given At Discharge)

Medication and Strength	Route	Freq	Last Dose (if IV)
	☐ PO ☐ IV		
	☐ PO ☐ IV		
	☐ PO ☐ IV		
	☐ PO ☐ IV		
	☐ PO ☐ IV		
	☐ PO ☐ IV		
	☐ PO ☐ IV		
	☐ PO ☐ IV		
	☐ PO ☐ IV		
	☐ PO ☐ IV		
	☐ PO ☐ IV		
	☐ PO ☐ IV		
	☐ PO ☐ IV		
	☐ PO ☐ IV		

Referring Provider/RN: ______________________________ Signature ______________________ Date

PUBLIC COMMUNICABLE DISEASE DISCLOSURE

We have been witness to a rise in the incidence of numerous communicable diseases over the past few years. In order for our staff to properly care for patients and manage their illnesses effectively we require disclosure of known communicable disease diagnosis. This is especially true, but not limited to patients who have a history of TB, VRE, and MRSA. We will evaluate each case on an individual basis.

Tuberculosis

All homeless persons are at high risk for TB. Any homeless person being referred with a new cough, or change in a cough for three weeks or with pulmonary symptoms suggestive of pneumonia must have a Chest X-ray.

Any infiltrate, regardless of lobe or lobes, or any unexplained pleural effusion should be viewed as suspicious for TB. Consequently, any homeless person with the aforementioned respiratory symptoms and any sign of an infiltrate on CXR should be considered suspicious for TB until proven otherwise.

These patients will not be admitted to the Recuperative Care Unit until 3 AFB smears are negative, or the CXR shows definite signs of resolution on an antibiotic regimen, or the patient demonstrates clear clinical improvement (no fever for 24 hours or absence of a productive cough) after 72 hours on antibiotics.

High-risk patients for whom AFB's have not been sent will need to be cleared by the physician in charge of Recuperative Care prior to admission.

Person with AIDS are at greater risk for TB, and often the CXR can be negative. Consequently, any homeless patient with AIDS with a productive cough is required to have three negative AFB smears REGARDLESS OF CXR FINDINGS. These patients must be cleared by the physician in charge of Recuperative Care prior to admission

Referring Provider **ONLY:** ______________________________ ______________
Signature Date

JWCH INSTITUTE, INC.
Health & Medical Services

RECUPERATIVE CARE PROGRAM
Verification of Homelessness Form
(TO BE COMPLETED BY **REFERRING PROVIDER or Case Manager**)

VERIFICATION OF HOMELESSNESS

Date: ______________________

Institution/Referring Agency: ___________________________________

To: JWCH Recuperative Care Program,

- ☐ Mr.
- ☐ Mrs.
- ☐ Ms. ____

Stayed in our: ☐ Hospital ☐ Treatment Recovery Program ☐ Transitional Housing
☐ Other: __________________________________
from ___________________ to _________________ .

Before coming to our program/facility above, he/she had been living

- ☐ On the streets
- ☐ In a car/bus
- ☐ Other inappropriate places (i.e. Parks, abandoned buildings, restrooms etc.) or other places not fit for human habitation

from ___________________ to _________________ .

Should you have any questions or if I can be of further assistance, please do not hesitate to contact me at:

____
(Contact #)

Sincerely,

____
(Signature of Referring Institution)

JWCH INSTITUTE, INC.
Health & Medical Services

PROGRAM GUIDELINES: General Information

What is Recuperative Care?

Recuperative Care is a program operated & staffed by JWCH Institute Inc. that provides transitional housing, meals, case management and medical care to homeless persons who are recovering from an acute illness or injury. The Program offers short-term care to patients with conditions that would be exacerbated by living on the street, in shelters or other unsuitable places. The Program maintains 75 beds between two locations (45 beds at the Weingart Center in Downtown Los Angeles and 30 beds at Bell Shelter in Bell). Although there is 24-hour LVN/nursing coverage, it is not a skilled nursing facility. Please review the attached admission criteria carefully before submitting a formal application.

Who can make a referral?

A social worker, registered nurse or health care provider (doctor, NP, or PA-C) may call to initiate a referral and check on bed availability. Patients may not self-refer.

When to make a referral:

Referrals are accepted from 8 AM - 5 PM Monday thru Friday.

Making referral:

Contact the Recuperative Care operator at (213) 689-2131 or (213) 689-2132. If a bed is available and the referral is thought to be appropriate, the referring medical provider must complete the Recuperative Care Provider Referral Form. The completed referral form should be faxed to the Recuperative Care Bed Control Unit at (213) 624-2302.

What happens next?

Once the Provider Referral Form is received, the on-call Recup Provider will determine if the patient meets the Recuperative Care admission criteria. After review, the referring agency or provider will be notified (within a few hours) of **preliminary acceptance** or denial. If approved, the remainder of the Recuperative Care Referral Packet including chest x-ray, history & physical, medication reconciliation form, verification of homelessness, disease disclosure form, AND FOLLOW-UP APPOINTMENTS for specialty care (if needed) will need to be faxed to the Program Coordinator. Once the completed application is received, the Recuperative Care Provider will review the additional information and finalize the approval for acceptance into the program and determine placement location. The Intake Coordinator will then arrange the date and time for Recup admission and arrange for patient transportation if available.

Clients to be admitted must arrive at the Recuperative Care Unit by 4:30 PM Mon-Fri. **Other arrangements must be approved by the Recuperative Program Coordinator.**

Established Locations:

www.jwchinstitute.org

515 East 6th St. Second Floor Los Angeles, CA. 90021 Phone: 213.689.2132 Fax: 213.624.2302	5600 Rickenbacker Rd. Building 1-E Bell, CA. 90201 Phone: 323.263.8840 Fax: 323.263.8348

Of note:

1. **If a client is deemed medically unappropriate or requiring a higher level of care, does not have required medications upon arrival to our Recuperative Care Program, he/she will be returned to the referring facility.**
2. **Patients MUST BE PROVIDED a 30-day supply of all necessary medication unless a shorter course of administration is recommended.**
3. **Patients MUST BE PROVIDED with shoes upon discharge from referring facility. Patients may be returned otherwise.**
4. **Patients MUST BE PROVIDED with assistive device for ambulation if prescribed by referring facility.**

PROGRAM GUIDELINES: Criteria

Admission Criteria

Referrals are screened and evaluated by the on-call provider upon receiving the faxed Provider Referral Form which MUST BE COMPLETED by the responsible referring provider. A preliminary approval will be determined in a timely manner.

Patient must:

- Be homeless
- Have an acute medical illness
- Be independent in the Activities of Daily Living and medication administration
- Be willing to see an LVN or Registered Nurse every day and comply with medical recommendations
- Be bowel and bladder continent
- Be medically and psychiatrically stable enough to receive care in our Recuperative Care facility. Patient must not be suicidal or homicidal.
- Have a condition with an identifiable end point of care for discharge.

Exclusion Criteria

- Sex offender
- Child molester
- Arsonist
- History of assault on a police officer
- Patients with unstable medical or psychiatric conditions that require an inpatient level of care.
- Patients requiring IV hydration (Patients requiring IV Antibiotic must be able to self-administer or arrange to have a Home Health Nurse come to the Recup Care location to assist the patient)
- Active substance abusers unable or unwilling to abstain during the Recup Care process.
- Home oxygen

PROGRAM GUIDELINES: Required Documentation

● STEP 1. Paperwork required to obtain preliminary approval of acceptance:

From ALL Referring Agencies:

1. Provider Referral Form - Must be completed by REFERRING PROVIDER ONLY. This is the only form needed to initiate the referral process and to obtain a preliminary approval for acceptance into the program.

● STEP 2. Paperwork required after preliminary approval of acceptance and prior to admission:

From hospital/inpatient:

1. Recuperative Care Case Manager Program Referral Form
2. Initial History and Physical and Discharge Summary
3. All pertinent labs and other related clinical and diagnostic studies.
4. Psychiatric or substance abuse consultations.
5. All pertinent social service information
6. Follow up appointments for specialty care, if applicable
7. TB status or other ID disclosure. (MRSA, VRE, etc)
8. Public Communicable Disease Disclosure
9. Verification of Homeless
10. Medication Reconciliation Form (with frequency and dosage of administration.) Please listyonl medication which patient will be provided upon discharge.

From Emergency and Outpatient Department:

1. Recuperative Care Case Manager referral form
2. ER/Outpatient History and Physical
3. All pertinent clinical information, labs, x-rays etc.
4. Follow-up appointments
5. Medication Reconciliation Form (with frequency and dosage of administration)
6. TB status and other ID disclosure (MRSA, VRE, etc)
7. Public Communicable Disease Disclosure
8. Verification of Homelessness

From Shelters/Clinics

1. Recuperative Care Case Manager Referral form
2. Copies Progress Notes/Physical Exam note detailing acute medical need
3. Copies of pertinent clinical and social service information.
4. Copies of recent discharge paperwork from Hospital or ER visit.
5. List of current medications (with frequency and dosage of administration)
6. TB status and other ID disclosure (MRSA, VRE, etc)
7. Public Communicable Disease Closure
8. Verification of Homeless