NATIONAL HEALTH CARE for the HOMELESS COUNCIL

Proposed Standards for Medical Respite Programs

Field Test Version 1.1

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Standard 2: Medical respite program provides quality environmental services

Like other clinical settings, medical respite programs must manage infectious disease, handle biomedical and pharmaceutical waste, and respond to emergencies and other crisis situations. Medical respite programs should follow applicable local or state guidelines and regulations related to hazardous waste handling and disposal, disease prevention, and safety. Written policies and procedures described below should reflect applicable local, state, or federal guidelines and regulations.

Criteria:

1. The medical respite program has a written policy and procedure for safe storage, disposal and handling of biomedical and pharmaceutical waste, including expired or unused medications and needles.

2. The medical respite program has a written protocol for managing exposure to bodily fluids and other biohazards.

3. Any medical respite program that is authorized to store medication for patients has a written policy to address storage, handling, security, disposition, and return to storage by staff and patients. The written policy describes how controlled medications are stored (and administered, if authorized and applicable) to prevent diversion.

Standard 2

4. Medication is stored according to manufacturers' recommendations or, in the absence of such recommendations, according to pharmacist or provider instructions. Medication storage areas are inspected periodically, as defined by the organization, to verify that medications are stored properly.

5. The medical respite program has written protocols in place to promote infection control and the management of communicable diseases (e.g. scabies, MRSA).

6. The medical respite program follows applicable reporting requirements for communicable diseases.

7. The medical respite facility has a contract in place for routine pest and rodent control and maintenance.

Standard 3: Medical respite program manages timely and safe care transitions to medical respite from acute care, specialty care, and/or community settings

Care transitions refer to the movement of patients between health care locations, providers, or different levels of care within the same location as their conditions and care needs change. Care transition initiatives aim to improve quality and continuity of care and reduce the chances of medical errors that can occur when patient care and information is transferred to another provider.

Criteria:

1. The medical respite program takes steps to ensure that medical respite is considered an option in discharge planning. This might include written agreements between major referring organizations and the medical respite program.

2. The medical respite program maintains an admissions policy and criteria for making admitting decisions. These admissions criteria are approved by the Medical Director overseeing the health care service delivered as part of the medical respite program. Qualified medical respite personnel make admission decisions.

3. The medical respite program reviews admission applications and makes admission decisions in a timely manner.

4. The medical respite program accepts patients based on its ability to keep patients safe and provide the care, treatment, and services needed by the patient.

5. When beds are unavailable, the medical respite program provides the referring organization with an estimation of availability with updates provided at predetermined intervals.

Standard 3

6. If a prospective patient is not accepted after referral and preadmission screening, the reasons for denying admission are documented and explained to the referring organization.

7. The medical respite program has designated point(s) of contact for referring organizations.

8. The medical respite program maintains policies and/or agreements as necessary to reduce barriers to accessing the medical respite program related to transportation.

9. Adequate protocols are in place for transferring patient information (or access to e-record). Protocols must include process for adherence to patient privacy rights under HIPAA.

10. The medical respite program ensures that the patient has an accountable provider at all points of care transition.

11. For those patients referred from a clinical setting, after admission is approved, a discharge summary for the patient is requested. If a discharge summary cannot be made available upon transfer, the medical respite program requests patient information on the following:

- Admission history and physical assessment
- Description of hospital course
- Discharge medication list
- Follow up instruction list
- Any specialty care and/or primary care follow up appointments made while at the referring institution

- Patient education/after care instructions
- List of pending procedures or labs that require follow up
- Communicable disease alerts
- Behavioral alerts
- Any pain management plan
- Any follow-up actions needed as a result of health insurance applications or other benefits initiated while at the referring institution
- Contact information for medical personnel involved in the patient's care

12. Appropriate medical respite staff reconciles medication or verifies medication reconciliation performed by a referring provider upon admission.
13. Medical respite program staff reinforces discharge instructions and reassesses patient's ability to follow instructions.
14. Medical respite program provides patient with contact information for outpatient/community providers involved in their care.

Policy#: 0106	**JWCH Institute, Inc.** **Policies & Procedures**	**Approved By:** Dr. P. Gregerson, CMO A. Ballesteros, CEO
Policy Title: Handling and Control of Infectious/Biohazardous Waste		**Effective Date:** July 2010 **Date Revised:**
Distribution: All Clinics		**Manual:** Exposure/Infection Control

POLICY

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Policy and procedures are established to ensure that infectious waste is handled and disposed of in accordance with all applicable laws and regulations.

PROCEDURE

1. Infectious waste must be handled and disposed of in accordance with all applicable laws and regulations of the Department of Environmental Health Services of the County of Los Angeles and any other local health laws and regulations.

2. Infectious waste must be separated from other waste at the point of origin in the producing facility.

3. The area for storage of infectious/biohazardous waste must be secured so as to deny access to unauthorized persons and must be marked with a warning sign on or adjacent to the exterior entry doors, gates or lids.

4. Medical wastes are hauled to a permitted offsite medical waste treatment facility, to a transfer station, or to another registered generator for consolidation. Hauling is by a registered hazardous waste transporter or by a person with an approved limited-quantity hauling exemption granted by the CA DHS Waste Management Division. When hauling medical wastes, the transporter carries the exemption form in the transporting vehicle.

5. A medical waste tracking document is maintained that includes the name of person transporting, number of waste containers, type of medical wastes and date of transportation. Tracking documents is kept a minimum of 3 years for large waste generators and 2 years for small generators.

6. "Medical waste" includes all of the following:
    a. Viral hazardous waste or sharps waste
    b. Waste which is generated or produced as a result of the diagnosis, treatment or immunization of patients.

7. "Biohazardous waste" means any of the following:
    a. Laboratory waste, including, but not limited to all of the following:
        1. Human specimen cultures from medical and pathological laboratories.
        2. Wastes from the production of bacteria, viruses or the use of spores, discarded live and attenuated vaccines and culture dishes and devices used to transfer inoculate and mix cultures.
    b. Waste containing any microbiologic specimens sent to a laboratory for analysis.
    c. Human surgery specimens or tissues removed at surgery, which are suspected by the attending physician and surgeon of being contaminated with infectious agents known to be contagious to humans.

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d. Waste, which at the point of transport from site, at the point of disposal, or thereafter, contains recognizable fluid blood products.
e. Containers or equipment containing fluid blood products, which are known to be infected with diseases that are highly communicable to humans.
f. Waste containing discarded materials contaminated with excretion, exudates, or secretions from humans who are required to be isolated by infection control staff, the attending physician or surgeon or the local health officer, to protect others from highly communicable diseases.

8. "Sharps waste" means any device having acute rigid corners, edges or protrusions capable of cutting or piercing, including but not limited to the following:
   a. Hypodermic needles, syringes, blades, and needles with attached tubing.
   b. Broken glass items, such Pasteur pipettes and blood vials contaminated with other medical waste.

9. Sharps containers will be placed close to the immediate area where sharps are used. Sharps container will be a rigid puncture resistant container which, when sealed, is leak resistant and cannot be reopened without great difficulty.

10. Sharps containers will be inaccessible to unauthorized persons. Security of containers in patient care area is maintained at all times.

11. Sharps containers will not be filled over manufacturer's designated fill line or more than ¾ full.

12. Sharps containers will be labeled with the words "sharps waste" or with the international biohazard symbol and the word "Biohazard".

Policy#: 0200	**JWCH Institute, Inc.** **Policies & Procedures**	**Approved By:** Dr. P. Gregerson, CMO Mel Baron, Pharmacy Consultant Michelle Lee, CCH Pharmacist
Policy Title: Outdated and deteriorated medications		**Effective Date:** July 2010
		Date Revised:
Distribution: All Clinics		**Manual :** Dispensary

POLICY

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It is the policy of JWCH Institute, Inc. to remove from the stock all medications that are outdated and deteriorated.

PROCEDURE

1. The nursing supervisor, pharmacist, or designee will perform an inventory of all medications in stock and examine for any expired or deteriorated medications in the dispensary department every month.

2. The inventory of drugs will include all medications purchased from pharmaceutical companies, PAP meds, sample drugs and any donated drugs.

3. All outdated, unused, and/or deteriorated drugs will be removed from the shelves and disposed of in a pharmaceutical waste container.

4. The nursing supervisor, pharmacist, or designee will document in a log the name of the drug, strength of the drug, expiration date, lot number and the quantity of drug(s) to be disposed. If drug(s) to be disposed is returned drug from patient(s) after dispensed, the name of the patients will also be documented at the time of disposal.

5. The record of deteriorated, outdated, and/or returned medication(s) will be kept on file in the dispensary department for a minimum of 1 year.

Policy#: 0112	**JWCH Institute, Inc.** **Policies & Procedures**	**Approved By:** Dr. P. Gregerson, CMO A. Ballesteros, CEO
Policy Title: Post Exposure to Blood Borne Pathogen: Evaluation and Follow Up	 S2: C-2 Click here to return to Standards Page	**Effective Date:** July 2010 **Date Revised:**
Distribution: All Clinics		**Manual:**Exposure/Infection Control

POLICY

Following report of an exposure incident to blood/body fluids, JWCH Institute, Inc. provides the exposed employee with a confidential medical evaluation. The Nurse Supervisor ensures that a medical provider and schedule necessary follow-up examine the employee. The Employee Health Nurse Manager oversees this process that includes the following:

- Documentation of route(s) of exposure and the circumstances under which the exposure incident occurred.
- Identification and documentation of the patient source unless the source is unknown.
- The exposed employee and source individual's blood shall be collected as soon as feasible and tested after consent is obtained.
- Testing of patient source blood for Hepatitis B, Hepatitis C and HIV to determine infectivity and VDRL status (if patient approves). Test results of patient source shall be made available to the exposed employee, followed by written notification within fifteen (15) days of evaluation completion.
- Test results are maintained confidentially in the employee health record.
- Exposed employee is tested Complete Hepatitis Panel and HIV; also, VDRL and LFT shall be done. If exposed employee consent to baseline blood collection, but does not give consent at that time for HIV serologic testing, the sample shall be preserve for 90 days by the contracted laboratory. If, within 90 days of the exposure incident, the employee elects to have the baseline sample tested, such testing shall be done as soon as feasible.
- JWCH Institute, Inc. provides to the exposed employee counseling and evaluation of reported illness.

PROCEDURE

1. Initial first aid is provided to the exposed employee. Wounds and skin sites that have been in contact with blood or body fluids shall be washed with soap and water; mucous membranes should be flushed with water. There is no evidence that the use of antiseptics for wound care or expressing fluid by squeezing the wound further reduces the risk of HIV transmission. However, the use of antiseptics is not contraindicated. The application of caustic agents (e.g. bleach) or the injection of antiseptics or disinfectants into the wound is not recommended.

2. Employee informs Nurse Supervisor immediately or as soon as after first aid is provided, that an exposure incident have occurred. If the exposed employee works in a JWCH Clinic Facility, the Clinic Administrator will inform the Chief Nursing Officer or Chief Medical Officer where the employee is being seen.

3. Nurse Supervisor takes History and assists employee fill-in forms. Doctor's First Report of Work Injury Form, the Claim for WC Benefits (DWC form) sections 1 through 8, as well the Exposure Incident Report. It is important to complete the section regarding information on the source of exposure as completely as possible to expedite the incident investigation. If source patient is still in the facility, explain to the patient what has occurred and ask them to stay.

Policy#: 0112	**JWCH Institute, Inc.** **Policies & Procedures**	**Approved By:** Dr. P. Gregerson, CMO A. Ballesteros, CEO
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4. Nurse Supervisor takes the employee to designated provider on duty for evaluation and/or treatment. Exposures to certain diseases require prophylaxis to be started immediately after an exposure.

5. Nurse Supervisor ensures that the medical provider have available JWCH Exposure Control with information of the Blood- Borne Pathogens Standard, Provider Guidelines Post-Exposure, a copy of the Exposure Incident Report where is documented the route of exposure and the circumstances under which the exposure occurred, and all the medical records that is relevant to the appropriate treatment of the employee, including his/her vaccination status.

6. Check if any blood specimens were obtained from the patient and if so, keep them.

7. A JWCH designated provider evaluates the type of blood/body fluid exposure, and examines the wound. Appropriate evaluation and treatment shall be initiated, which may include various lab tests run on the source of exposure, as well as the exposed employee, immunizations, and/or medication including HIV medication treatment as needed.

8. Nurse Supervisor or designee completes provider orders. Draw blood test to employee and source patient according to protocol and Doctor's orders. On all laboratory requisitions, write "Hand Deliver Results to Nursing Supervisor".

9. Nurse Supervisor files all documentation in employee's WC medical records that shall be open when an employee has a work-related injury/illness.

10. Nurse Supervisor sends via fax Doctor's First Report of work injury (completed by the provider), Blood borne pathogens Exposure Report and Sharp Injury Log Form to the Chief Nursing Officer within one business day.

11. Nurse Supervisor arranges Follow-up and Referral to Specialist assisted/directed by the Chief Nursing Officer.

B. When laboratory results are obtained the Nurse Supervisor will:

1. Pull employee's WC medical records and attach employee and source laboratory test results.
2. Give to designated provider for review. Have employee meet with provider to review test results.
3. Ensure that the medical provider completes the Post-Exposure Medical Evaluation Report. The original goes to the employee, copy goes in employee WC medical record and a copy sent to the EHN with lab results of the employee and source individual, within one business day.
4. Schedule appointments for follow-up visit and blood test as recommended by the medical provider.

JWCH INSTITUTE, INC.
John Wesley Community Health

Exposure Event No._____

BLOOD AND BODY FLUID EXPOSURE REPORT FORM

Facility name: _____

Name of exposed worker: Last _____ First _____ ID # _____

Date of exposure: _____/_____/_____ Time of exposure: _____:_____ AM PM (Circle)

Job Title/Occupation:_____ Department/Work Unit: _____

Location where exposure occurred: _____

Name of person completing form: _____

Section I. Type of Exposure (Check all that apply)

☐ **Percutaneous** (Needle or sharp Object that was in contact with blood or body fluids)
(Complete Sections II, III, IV, and V.)

☐ **Mucocutaneous** (Check below and complete Sections III, IV, and VI.)
___ Mucous Membrane ___ Skin

☐ **Bite** *(Complete Sections III, IV, and VI.)*

Section II. Needle/Sharp Device Information

(If exposure was percutaneous, provide the following information about the device involved)

Name of device: _____ ☐ Unknown/Unable to determine

Brand/Manufacturer: _____ ☐ Unknown/Unable to determine

Did the device have a sharps injury prevention feature, i.e., a "safety device"?

☐ Yes ☐ No ☐ Unknown/Unable to determine

If yes, when did the injury occur?

☐ Before activation of safety feature was appropriate ☐ Safety feature failed after activation

☐ During activation of the safety feature ☐ Safety feature not activated

☐ Safety feature improperly activated ☐ Other: _____

Describe what happened with the safety feature, e.g., why it failed or why it was not activated: _____

_____

Section III. Employee Narrative (Optional)

Describe how the exposure occurred and how it might have been prevented: _____

_____

Section IV. Exposure and Source Information

A. Exposure Details: (Check all that apply.)

1. **Type of fluid or material** (For body fluid exposures only, check which fluid in adjacent box.)

☐ Blood/blood products

☐ Visibly bloody body fluid*

☐ Non-visibly bloody body fluid*

☐ Visibly bloody solution (e.g., water used to clean a blood spill)

*Identify which body fluid
__ Urine __Semen/Vaginal
__ Sputum __Semen/Vaginal
__ Saliva __ Other/Unknown

2. **Body site of exposure** (Check all that apply.)

☐ Hand/finger ☐ Eye ☐ Mouth/nose ☐ Face

☐ Arm ☐ Leg ☐ Other (Describe:_____)

3. **If percutaneous exposure:**
Depth of Injury (Check only one)

☐ Superficial (e.g., scratch, no or little blood)

☐ Moderate (e.g., penetrated through skin, wound bled)

☐ Deep (e.g., intramuscular penetration)

☐ Unsure/Unknown

Was blood visible on device before exposure? ☐ Yes ☐ No ☐ Unsure/Unknown

4. **If mucous membrane or skin exposure:** (Check only one.)
Approximate volume of material

☐ Small (e.g., few drops)

☐ Large (e.g., major blood splash)

If skin exposure, was skin intact? ☐ Yes ☐ No ☐ Unsure/Unknown

B. Source Information

1. Was the source individual identified? ☐ Yes ☐ No ☐ Unsure/Unknown

2. Provide the serostatus of the source patient for the following pathogens.

	Positive	Negative	Refused	Unknown
HIV Antibody	☐	☐	☐	☐
HCV Antibody	☐	☐	☐	☐
HbsAg	☐	☐	☐	☐

3. If known, when was the serostatus of the source determined?

☐ Known at the time of exposure

☐ Determined through testing at the time of or soon after the exposure

MEDICATION HANDLING

1) Keep work area neat and clean.

2) Wash hands prior to handling any medication.

3) All medications should be dispensed in childproof containers unless otherwise specified by the patient or the patient's caregiver.

4) When multidose medications are first opened, they must be labeled with the opened date and initialed.

   - Multi-use vials shall be kept refrigerated according to the directions on the label.

5) Bulk medications must be sent to the repackager within 14 days of receipt.

6) Staff who have been trained in handling medications are responsible for:

   - Inputting prescription information into the dispensary log.
   - Transferring the label with prescription information from the log onto the medication container.
   - Transferring the labels (3) with medication record information from the medication container onto the log, patient chart, and bill.
   - Properly placing medications in the order to be dispensed for the Medical Providers.

7) The Medical Providers are responsible for:
   a) Checking the final product for the correct medication, strength, dosage form, direction, number of pills, and patient's name in comparison to the original prescription.
   b) Assessing the correct use of auxiliary labels.
   c) Initialing the typed label signifying that steps a) and b) are correct.

8) A preprinted patient advisory leaflet in English and Spanish will accompany the dispensed medication.

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JWCH INSTITUTE, INC.
Recuperative Care Program

Assisted Medication Program
Policy and Procedure

Policy:

Residential staff are responsible to assist residents in complying with prescribed medication regimens, when indicated. For residents on an Assisted Medication Program, residential staff are responsible for insuring that residential clients have access to already prescribed medication at the prescribed time and tracking adherence by recording appropriate information on the medication sheet. Any concerns about adherence with medication need to be brought to the attention of the clinic staff, provider, or JWCH Chief Medical Officer.

Procedures:

1. Healthcare staff, in consultation with residential and clinical team members, will determine if a resident will be placed on "Assisted Medication" regimen. This determination will be based upon the client's demonstrated consistency in taking medication, their stability, cognitive state, adherence barriers etc.

2. The Person In Charge (PIC) is responsible for ensuring that clients enrolled in the "Assisted Medication Program" take their medication as prescribed and the documentation thereof. Enrolled clients will have their medication placed in a Medication Cart that will be locked and maintained in a safe and secure area.

3. At the beginning of the shift, the PIC or designated staff reviews the client and medication(s) that are to be observed during the shift.

4. The PIC or designated staff (see above) is responsible for ensuring that medications are made available to clients at the time they are prescribed.

5. The designated staff hands the medication bottle to the client and the client is then instructed to check the bottle to verify ownership. The designated staff then observes the resident taking the medication as prescribed. When the client has finished taking their medication, the designated staff will ensure that the Med Cart is locked.

6. If the client does not come to the designated area to take their medications, the designated staff will attempt to find the patient and encourage them to comply.

7. The PIC or designated staff then records on the med log the following:

    - The date and time, and either T, A, or R (Taken, Absent, Refused) and signs the corresponding box

JWCH INSTITUTE, INC.
Recuperative Care Program

- If the client is absent or refuses to take their medication then the Case Manager and Provider need to be emailed the information.

8. The PIC will maintain the medication log and ensure the medication is kept in a safe and secure area.

9. In order to ensure confidentiality of other clients, only one client at a time will be taken by the designated staff person to get their medication. The staff person will hand the medication bottle to the client to avoid the client from seeing other client's names on the medication bottles or containers.

10. If a client is no longer residing in the building and does not pick up their medication prior to departure, the medication will be removed from the cart and disposed of in a predetermined manner. Under no circumstances is the medication to be reused or given to another client.

11. Policies and Procedures will reviewed and approved annually by Chief Medical Officer.

Policy: 0202	**JWCH Institute, Inc.** **Policies & Procedures**	**Approved By:** Dr. P. Gregerson, CMO Mel Baron, Pharmacy Consultant Michelle Lee, CCH Pharmacist
Policy Title: Medication Storage In the Dispensary Dept.		**Effective Date:** July 2010 **Date Revised:**
Distribution: All Clinics		**Manual :** Dispensary

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POLICY

To ensure that all drugs are properly labeled, stored and maintained according to manufacturer's recommendations and guidelines. The quality and appropriateness of medication usage at the Dispensary department will be monitored and evaluated. Such evaluation will be a part of the JWCH Institute, Inc. ongoing Drug Utilization Review.

PROCEDURE

1. All prescription pads shall be stored in the Practitioner's desk drawer, in the Nursing Supervisor's desk drawer, or in the clinic supply area. Prescription pads shall not be stored or left even temporarily in patient areas of the clinic.

2. All drugs will be checked for expiration prior to administering. Expiration dates of all medications, including samples, will be checked once a month.

3. All medications will be stored in a secured manner in the dispensary with access limited to authorized personnel only.

4. All external medications shall be stored separately from internal medications.

5. All drugs will be properly labeled. Multiple-dose vials will be dated when opened and discarded after 30 days, unless expiration date is sooner.

6. Items other than medication stored in the dispensary or vaccine refrigerator will be kept in a secured separate compartment (no food in refrigerator).

7. Medication and vaccine refrigerator temperatures must be checked and recorded daily on separate logs. The refrigerator temperatures will be maintained between 35 to 46 degrees F, or 2 to 8 degrees C. Freezer will be maintained at 5 degrees F or less or 15 degrees C or less.

8. No vaccines will be kept in the refrigerator door.

9. Care will be taken to ensure that medications shall be stored, locked, and maintained according to manufacturer's recommendations in regards to temperature, humidity, light protection, and sterility.

MEDICATION STORAGE POLICIES

- All medications shall be stored and locked inside the dispensary, and only employees legally authorized to dispense may have access to the dispensary room.
- All external medications shall be stored separately from internal medications.
- All germicides, disinfectants, test reagents, and household cleaning substances shall be stored separately from medications.
- Care shall be taken to ensure that medications shall be stored, locked, and maintained according to manufacturer's recommendations in regards to temperature, humidity, light protection, and sterility.
- All prescription pads shall be stored in the Medical Providers' drawer, or in the clinic supply area. Prescription pads shall not be stored or left even temporarily in patient areas of the clinic.

Policy#: 0103	**JWCH Institute, Inc.** **Policies & Procedures**	**Approved By:** Dr. P. Gregerson, CMO A. Ballesteros, CEO
Policy Title: Disposition of Patients with Contagious Diseases.		**Effective Date:** July 2010
		Date Revised:
Distribution: All Clinics		**Manual:**Exposure/Infection Control

POLICY

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Infection control standards will be practiced in order to minimize risk of disease transmission from patients with infectious/contagious diseases.

PROCEDURES

1. Patients with known or suspected communicable diseases/conditions will call in advance to schedule an appointment. They will be advised to go directly to the receptionist's window upon arrival at the office.

2. The receptionist will immediately notify the medical assistant or nurse of the patient's arrival and request that the patient remain at the receptionist's window until the medical assistant or nurse arrives to escort him/her to the exam room.

3. Ideally, an alternate entrance that would facilitate direct placement into the designated exam room is preferred.

4. Masks covering both the nose and mouth will be worn by all personnel having close contact with the patient. Masks may be worn only once and should be discarded before leaving the room. Gloves and gown are not indicated.

5. Thorough hand washing is to be done upon entering and leaving the room. Discard all disposable waste materials which have or may have come in contact with the patient in the trash container designated for infectious waste.

6. Re-usable instruments/materials should be bagged and labeled before being sent to the "dirty" utility area for decontamination.

   Diseases requiring isolation:

   Epiglottis, Hemophilus Influenza
   Measles, Rubeola
   Meningitis – H Flu
   Meningococcal Pneumonia
   Meningococcemia
   Mumps
   Pertussis (Whooping Cough)
   Hemophilus Influenza Pneumonia (in children any age)
   Scabies
   MRSA

7. Once patient leaves the exam room, Nursing Supervisor will disinfect it and room will not be used for the next 20 minutes.

Policy#: 0103	**JWCH Institute, Inc.** **Policies & Procedures**	**Approved By:** Dr. P. Gregerson, CMO A. Ballesteros, CEO
Policy Title: Disposition of Patients with Contagious Diseases.		**Effective Date:** July 2010
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Distribution: All Clinics		**Manual:**Exposure/Infection Control

8. There will be a "Do Not Use" sign posted on the exam room door.

JWCH INSTITUTE, INC. Health & Medical Services

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

Patient Name: _____
Please Print

Referring Provider **ONLY:** _____ _____
Signature Date

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PROCEDURES FOR REPORTING COMMUNICABLE DISEASE

REPORTABLE DISEASES

California Administrative Code, Section 2500

Any incidence of the diseases listed on the following page is to be reported to the health department (city or county) by faxing the State Department of Public Health Confidential Morbidity Report Form to 888.397.3778 or for assistance, call the Morbidity Unit at 888.397.3993.

Forms for the Los Angeles County Sexually Transmitted Disease Confidential Morbidity Report may be faxed to 213.749.9602 or Mail to:

STD Program 2615 S. Grand Avenue, RM. 450
Los Angeles, CA 90007

For HIV Reporting, call: 213.351.8516

WHO SHOULD REPORT

Medical doctors, osteopaths, podiatrists, nurse practitioners, physician assistants, nurses, nurse midwives, infection control practitioners, medical examiners, coroners, dentists, and administrators of health facilities and clinics knowing of a case of a communicable disease, are required to report them to the local health department (Section 2500).

Reportable Communicable Diseases

- Acquired Immune Deficiency Syndrom (AIDS)
- Amebiasis ③
- Anisakiasis ③
- Anthrax ①
- Babesiosis ③
- Botulism (Infant, Foodborne, or Wound) ①
- Brucellosis
- Campylobacteriosis ③
- Chancroid
- Chlamydial Infections
- Cholera ①
- Ciguatera Fish Poisoning ①
- Coccidioidomycosis
- Colorado Tick Fever ③
- Conjuctivitis, Acute Infectious of the Newborn (specify etiology) ③
- Cryptosporidiosis ③
- Cysticercosis
- Dengue ①
- Diarrhea of the Newborn (outbreaks) ①
- Diphtheria ①
- Domoic Acid Poisoning (Amnesic Shellfish Poisoning) ①
- Echinococcosis (Hydatid Disease)
- Ehrlichiosis
- Encephalitis – Viral, Bacterial, Fungal, or Parasitic (specify etiology) ③
- *Escherichia coli* 0157:H7 Infection ①
- Foodborne Disease (food poisoning) ② ③
- Giardiasis
- Gonococcal Infections
- *Haemophilus influenzae* (invasive disease) ③
- Hantavirus Infections ①
- Hemolytic Uremic Syndrome ①
- Hepatitis Viral
- Hepatitis A ③
- Hepatitis B (specify acute or chronic case)
- Hepatitis C (specify acute or chronic case)
- Hepatitis D (Delta)
- Hepatitis, other, acute
- Kawasaki Syndrome (Mucocutaneous Lymph Node Syndrome)
- Legionellosis
- Leprosy (Hansen's Disease)
- Leptospirosis
- Listeriosis ③
- Lyme Disease
- Lymphocytic Choriomeningitis ③
- Malaria ③
- Measles (Rubeola) ③
- Meningitis – Viral, Bacterial, Fungal, or Parasitic (specify etiology) ③
- Meningococcal Infections ①
- Mumps
- Non-Gonococcal Urethritis (Excluding Laboratory Confirmed Chlamydial Infections)
- Paralytic Shellfish Poisoning ①
- Pelvic Inflammatory Diseas (PID)

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- Pertussis (Whooping Cough) ③
- Plague (Human or Animal) ①
- Poliomyelitis, Paralytic ③
- Psittacosis ③
- Q Fever ③
- Rabies (Human or Animal) ①
- Relapsing Fever ③
- Reye Syndrome
- Rheumatic Fever, Acute
- Rocky Mountain Spotted Fever
- Rubella (German Measles)
- Rubella Syndrome, Congenital
- Salmonellosis (Other than Typhoid Fever) ③
- Scabies (Atypical or Crusted)*
- Scombroid Fish Poisoning ①
- Shigellosis ③
- Smallpox (Variola) ①
- Streptococcal Infections (Outbreaks of any type and individual cases in food handlers and dairy workers only) ③
- Swimmer's Itch (Schistosomal Dermatitis) ③
- Syphilis ③
- Tetanus
- Toxic Shock Syndrome
- Toxoplasmosis
- Trichinosis ③
- Tuberculosis ③
- Tularemia
- Typhoid Fever (specify whether case or carrier) ③
- Typhus Fever
- Varicella (Deaths only) ①
- *Vibrio* Infections ③
- Viral Hemorrhagic Fevers (e.g., Crimean – Congo, Ebola, Lassa and Marburg viruses)
- Water-associated Disease ③
- Yellow Fever ①
- Yersiniosis ③
- **Occurrence of Any Unusual Disease**
- **Outbreaks of any disease** (Including diseases not listed in Section 2500). Specify if institutional and/or open community. ①
- **Reportable, Non-Communicable Diseases or Conditions**
  Alzheimer's Disease and Related Conditions
  Disorders Characterized by Lapses of Consciousness

① To be reported immediately by telephone.

② When two (2) or more cases or suspected cases of foodborne illness, they should be reported immediately by telephone.

③ To be reported by mailing ar eport, telephoning, or electronically transmitting a report within one (1) working day of identification of the case or suspected case.

All other conditions to be reported within seven (7) calendar days by mail, telephone, or electronic report from the time of identification.

* Reportable to Los Angeles Health Department

CONFIDENTIAL MORBIDITY REPORT

DATE OF REPORT ☐☐ - ☐☐ - ☐☐ REPORT STATUS: ☐ New ☐ Update REPORT DONE BY:

Public Health

1 PROVIDER

DIAGNOSING MEDICAL PRACTITIONER (LAST NAME & FIRST NAME) | TITLE ABBREVIATION

FACILITY/CLINIC NAME | SUITE/UNIT NO.

FACILITY/CLINIC STREET ADDRESS

CLINIC STAMP

CITY/TOWN

STATE | OFFICE TEL. ( ) -

ZIP CODE | OFFICE FAX ( ) -

JWCH INSTITUTE, INC. BELL RECUPERATIVE CARE
5600 Rickenbacker Road, Bldg 1E
Bell, CA 90201

2 PATIENT INFORMATION

PATIENT'S LAST NAME | FIRST NAME | M.I.

MEDICAL RECORD NUMBER | SOCIAL SECURITY NUMBER - - | OCCUPATION

PATIENT'S STREET ADDRESS | APT/UNIT NO.

CITY/TOWN | STATE | ZIP CODE

DAY TEL. ( ) -

EVENING TEL. ( ) -

AGE: | BIRTHDATE: - -

PREGNANT? ☐ Unknown ☐ No ☐ Yes ▶ If yes, date of LMP: - -

HIV cases must be reported to **LA County HIV Epidemiology Program** (see section 5)

GENDER:
- ☐ Male
- ☐ Female
- ☐ Transgender (M to F)
- ☐ Transgender (F to M)
- ☐ Unknown
- ☐ Other

MARITAL STATUS:
- ☐ Single
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed
- ☐ Living with Partner

RACE (X all that apply):
- ☐ White
- ☐ Black or African American
- ☐ Native American or Alaska Native
- ☐ Asian or Asian American
- ☐ Native Hawaiian or Pacific Islander
- ☐ Unknown
- ☐ Other:

ETHNICITY (X only one):
- ☐ Hispanic or Latino
- ☐ Non-Hispanic/ Non-Latino

GENDER of SEX PARTNERS:
- ☐ Male
- ☐ Female
- ☐ Transgender (M to F)
- ☐ Transgender (F to M)
- ☐ Other
- ☐ Unknown
- ☐ Refused

3 DIAGNOSIS & TREATMENT

CHLAMYDIA (including PID)

DIAGNOSIS (X one):
- ☐ Asymptomatic
- ☐ Symptomatic - uncomplicated
- ☐ Pelvic Inflammatory Disease
- ☐ Opthalmia/Conjunctivitis
- ☐ Other:

SITE / SPECIMEN(S) (X all that apply)
- ☐ Urine
- ☐ Cervix
- ☐ Vagina
- ☐ Urethra
- ☐ Rectum
- ☐ Nasopharynx
- ☐ Other:

Specimen Collection Date: ☐☐ - ☐☐ - ☐☐

Treatment Date: ☐☐ - ☐☐ - ☐☐ ☐ **Not treated**

Medication & Dose:

Partner Information: Number partners (last 60 days) | Number treated (not including PDPT) | Number Given Patient Delivered Partner Therapy (PDPT)

GONORRHEA (including PID)

DIAGNOSIS (X one)
- ☐ Asymptomatic
- ☐ Symptomatic - uncomplicated
- ☐ Pelvic Inflammatory Disease
- ☐ Opthalmia/Conjunctivitis
- ☐ Disseminated
- ☐ Other:

SITE / SPECIMEN(S) (X all that apply)
- ☐ Urine
- ☐ Cervix
- ☐ Vagina
- ☐ Urethra
- ☐ Rectum
- ☐ Nasopharynx
- ☐ Other:

Specimen Collection Date: ☐☐ - ☐☐ - ☐☐

Treatment Date: ☐☐ - ☐☐ - ☐☐ ☐ **Not treated**

Medication & Dose:

Partner Information: Number partners (last 60 days) | Number treated (not including PDPT) | Number Given Patient Delivered Partner Therapy (PDPT)

ADULT SYPHILIS

3 cont. DIAGNOSIS & TREATMENT

☐ **Primary Syphilis** Onset Date: ☐☐-☐☐-☐☐

LESION SITES (X all that apply): ☐ Genital ☐ Rectum ☐ Oral ☐ Other: ☐ Vagina ☐ Perirectal

☐ **Secondary Syphilis** Onset Date: ☐☐-☐☐-☐☐

SYMPTOMS (X all that apply): ☐ Palmar/Plantar Rash ☐ Other: ☐ General Body Rash ☐ Alopecia

☐ **Early Latent** (≤1 Year)
☐ **Late Latent** (>1 Year)
☐ **Latent, Unknown Duration**

☐ **Late Syphilis**
☐ **Neurosyphilis**
(The diagnosis of neurosyphilis must be accompanied by a staged diagnosis)

DESCRIBE SYMPTOMS

Specimen Collection Date: ☐☐-☐☐-☐☐

☐ RPR or ☐ VDRL **Titer:** 1 :

☐ TP-PA or ☐ FTA-ABS or ☐ Other **Reactive:** ☐ Yes ☐ No

☐ **CSF-VDRL** **Titer:** 1 :

PARTNER INFORMATION: Number elicited: ☐☐ Number treated: ☐☐

Patient Treated: ☐ Yes ☐ No (If **yes**, give treatment/dose & dates below)

DATE(S) TREATED	MEDICATION / DOSE
☐☐-☐☐-☐☐	
☐☐-☐☐-☐☐	
☐☐-☐☐-☐☐	

CONGENITAL SYPHILIS (SEPARATE CMRS SHOULD BE SUBMITTED FOR MOTHER & INFANT)

INFANT INFORMATION
(complete sections A & B if this is mother's CMR; Complete only B if this is infant's CMR)

A **INFANT'S LAST NAME**

INFANT'S FIRST NAME

INFANT'S BIRTH DATE ☐☐-☐☐-☐☐

GENDER ☐ M ☐ F

B **WEIGHT** (grams) ☐☐☐☐

GESTATION (wks) ☐☐ ☐ **Live Birth** ☐ **Still Birth**

DESCRIBE SYMPTOMS: ☐ None

Long Bone X-rays: ☐ Positive ☐ Negative ☐ Not Done

Serum RPR Lab. Test Date: ☐☐-☐☐-☐☐

☐ Reactive → **Titer:** 1 :
☐ Non-Reactive
☐ Not Done

Titer 4x> mothers? ☐ Yes ☐ No

CSF Laboratory Test Date: ☐☐-☐☐-☐☐

VDRL: ☐ Reactive ☐ Non-reactive

WBC >5/mm³: ☐ Yes ☐ No

Protein>50mg/dl: ☐ Yes ☐ No

DATE INFANT TREATED ☐☐-☐☐-☐☐

MEDICATION / DOSE

MATERNAL INFORMATION
(complete if this is infant's CMR)

MOTHER'S LAST NAME

MOTHER'S FIRST NAME

MOTHER'S BIRTH DATE ☐☐-☐☐-☐☐

Lumbar Puncture Done: ☐ Yes ☐ No

MOTHER'S SEROLOGY AT DELIVERY
Lab Test Date: ☐☐ ☐☐ ☐☐

☐ RPR or ☐ VDRL **Titer:** 1 :

☐ TP-PA or ☐ FTA-ABS or ☐ Other **Reactive:** ☐ Yes ☐ No

MOTHER'S STAGE OF SYPHILIS AT DIAGNOSIS
☐ Primary
☐ Secondary
☐ Early Latent (≤1 Year)
☐ Late Latent (>1 Year)
☐ Latent, Unknown Duration
☐ Late Syphilis

DATE(S) TREATED	MEDICATION / DOSE
☐☐-☐☐-☐☐	
☐☐-☐☐-☐☐	
☐☐-☐☐-☐☐	

OTHER REPORTABLE STDs

DIAGNOSIS	TREATED	DATE TREATED	MEDICATION / DOSE
☐ **Pelvic Inflammatory Disease** (complete if chlamydia & gonorrhea tests are negative or not available. If either test is positive, report in chlamydia &/or gonorrhea sections)	☐ Yes ☐ No	☐☐-☐☐-☐☐	
☐ **LGV**	☐ Yes ☐ No	☐☐-☐☐-☐☐	
☐ **Chancroid**	☐ Yes ☐ No	☐☐-☐☐-☐☐	

4 SEND

FAX BOTH SIDES TO: (213) 749-9602
or
MAIL TO: STD PROGRAM
2615 S. GRAND AVENUE, RM. 450
LOS ANGELES, CA 90007

5 INFO

TO REQUEST CMR FORMS & ENVELOPES: Call (213) 741-8000 or DOWNLOAD at: **www.lapublichealth.org/std/providers.htm**

FOR CASE DEFINITIONS & REPORTING QUESTIONS:
Visit **www.lapublichealth.org/std/providers.htm** or call (213) 744-3106

FOR HIV REPORTING: Call: (213) 351-8516 or visit **www.lapublichealth.org/hiv**

COUNTY OF LOS ANGELES
Public Health

MORBIDITY UNIT
CONFIDENTIAL MORBIDITY REPORT

NOTE: This form is not intended for reporting STDs, HIV, AIDS or TB. See comments below

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DISEASE BEING REPORTED:

DISTRICT CODE (internal use only):

Patient's Last Name:

Social Security Number:

Ethnicity (check one):
◯ Hispanic ◯ Non-Hispanic / Non-Latino

First Name and Middle Name (or initial):

Birthdate (MM/DD/YYYY):

Age:

Race (check one):
◯ White
◯ African American / Black
◯ Native American / Alaskan Native
◯ Other _____
◯ Asian / Pacific Islander
◯ Asian-Indian ◯ Japanese
◯ Cambodian ◯ Korean
◯ Chinese ◯ Laotian
◯ Filipino ◯ Samoan
◯ Hawaiian ◯ Other _____

Address (Street and number):

City/Town

State

Zip code

Home Telephone Number:

Work Telephone Number:

Gender:
◯ Male
◯ Female Pregnant? ◯ Yes ◯ No ◯ Unknown
Estimated Delivery Date: _____

Patient's Occupation or Setting:
☐ Day Care ☐ Correctional Facility ☐ Food Service (Explain): _____
☐ Health Care ☐ School ☐ Other (Explain): _____

Date of Onset (MM/DD/YYYY):

Date of Diagnosis (MM/DD/YYYY):

Date of Hospitalization (MM/DD/YYYY):

Date of Death (MM/DD/YYYY):

Health Care Provider:

Health Care Facility:

Address:

City:

Telephone:

FAX:

Submitted by:

Date CMR submitted (MM/DD/YYYY):

Risk Factors / Suspected Exposure Type:
(check all that apply)
☐ Blood transfusion
☐ Child care
☐ Food / drink
☐ Foreign travel
☐ Household exposure
☐ Needle or blood exposure
☐ Recreational water exposure
☐ Sexual activity
☐ Unknown
☐ Other _____

Type of diagnostic specimen: (check all that apply)
☐ Blood ☐ CSF
☐ Stool ☐ Urine
☐ Clinical ☐ No test
☐ Other _____

Hepatitis Diagnosis:
☐ Hep A, acute
☐ Hep B, acute
☐ Hep B, chronic
☐ Hep C, acute
☐ Hep C, chronic
☐ Hep D
☐ Other Hepatitis

Elevated LFTs?
◯ No ◯ Yes ____ ALT
____ AST

Jaundiced? ◯ No ◯ Yes

Type of Hepatitis Testing
(check all that apply):

	Pos.	Neg.	Pend.	Not Done
anti-HAV IgM	◯	◯	◯	◯
HBsAg	◯	◯	◯	◯
anti-HBc (total)	◯	◯	◯	◯
anti-HBc IgM	◯	◯	◯	◯
anti-HBs	◯	◯	◯	◯
anti-HCV	◯	◯	◯	◯
- anti-HCV signal to cut off ratio = _____				
HCV-PCR	◯	◯	◯	◯
anti-Delta	◯	◯	◯	◯
Other test	◯	◯	◯	◯

specify _____

DO NOT use this form to report HIV/AIDS, chancorid, chlamydia infections, gonorrhea, non-gonococcal urethritis, pelvic inflammatory disease, syphilis, or tuberculosis.

For HIV and AIDS: report to the HIV Epidemiology Program. Reporting information and forms are available by phone 213-351-8516 or at: www.publichealth.lacounty.gov/hiv/index.htm

For Pediatric AIDS: report to the Pediatric HIV/AIDS Reporting Program. Reporting information is available by calling 213-351-7319

For Tuberculosis: report cases and suspected cases to the TB Control Program within 24 hours of identification. Reporting information is available by phone 213-744-6160, or at www.publichealth.lacounty.gov/tb/index.htm Fax reports to: 213-744-0926.

For STDs: The STDs that are reportable to the STD Program include: chlamydial infections, syphilis, gonorrhea, chancroid, non-gonococcal urethritis (NGU), and pelvic inflamatory disease. Reporting information is www.publichealth.lacounty.gov/std/index.htm

REMARKS:

FAX THIS REPORT TO: 888-397-3778
For assistance, please call the Morbidity Unit at 888-397-3993, or mail to Morbidity Unit, 313 N. Figueroa St., #117, Los Angeles, CA 90012.

Sunday, April 5, 2015 4:41:55 PM Pacific Daylight Time

Subject: Re: Bell Shelter Policies
Date: Sunday, April 5, 2015 4:40:50 PM Pacific Daylight Time
From: Thanh Chu
To: Alexandra Tostes

From: Alexandra Tostes <alexandra.tostes@usw.salvationarmy.org>
Date: Wednesday, April 1, 2015 11:45 AM
To: Thanh Chu <USCmed2@aol.com>
Cc: Steve Lytle <steve.lytle@usw.salvationarmy.org>
Subject: Re: Bell Shelter Policies

Hello There,

We have a signed agreement with a pest control company for weekly straying. We keep very detailed records of their visits.

Alexandra Tostes, CAS II
Director of Operations
The Salvation Army Bell Shelter
5600 Rickenbacker Road, Building 2AB
Bell, CA 90201
O: 323.263-1206 F: 323.263.8543
alexandra.tostes@usw.salvationarmy.org
www.salvationarmy-socal.org
Follow The Salvation Army on Twitter, Facebook and YouTube!
Or sign up now to become a Salvation Army Insider!

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The Salvation Army Bell Shelter Policies and Procedures

Operations Department: PESTICIDE APPLICATIONS/DAILY USE RECORD/POSTING CHECK LIST

Employee Supervising Application: Rocky Hinds and Joe Poor	Applicator/Agency	Record #
Pesticide Applicator License #		Date

Conditions

*Note: Either the applicator or the direct supervisor must have valid certified applicator's number. Check with state pesticide regulatory agency for details.

Time of Application (a.m./p.m.)	Area/s	Additional Comments

Pesticides/Products Used

*Formalation is usually indicated by the label: Granular (G), Dust (D), Emulsifiable Concentrate (EC), Bait (B), Wettable Powder (WP), etc.

Treatment #	Trade Name	Formulation*	EPA Registration #	Target Pest(s)	Product Application Rate (e.g., oz/Acre, lb/1000 ft^2)

Application Details

Treatment #	MSDS	Equipment Used	Decal Number (if applicable)	Vol. or Weight of Product Applied	Area Treated (sq ft, etc.)	Comments

Maintenance Staff Checklist

☐ Was pre-notification posted? ☐ Was area posted after application? ☐ Did you check label reentry period? ☐ Did you list date and time of allowed reentry? List: _____

☐ Were clients present at time of application? Explain: _____ ☐ Was treatment watered-in after application? Explain: _____

☐ MSDS Sheets Posted? Staff Responsible: _____ ☐ Issues? Explain:

Operations Department Pest Sighting and Response Log

Initial Report		Department Action and Response			
Date Reported	**Room/Area/s Problem Description**	**Date Completed**	**Room/Area/s**	**Time In/Out**	**Service Completed By:**

Supervisor Review By: _____ **Date:** _____

Homeless Recuperative Care Services Agreement

THIS AGREEMENT is made and entered into by and between the **JWCH Institute, Inc.**, a non-profit organization, hereinafter referred to as **"JWCH",** and _____, located at _____ hereinafter referred to as **"HOSPITAL".**

WITNESSETH: It is hereby covenanted and agreed as follows:

WHEREAS, HOSPITAL desires to obtain recuperative care services for their homeless patients, hereinafter referred to as "CLIENT or CLIENTS," from JWCH after discharge from said HOSPITAL and JWCH is willing and ready to furnish such services upon the terms and conditions hereinafter more particularly set forth;

NOW, THEREFORE, in consideration of the terms, conditions, covenants and performance contained herein, the parties hereto agree as follows:

1. **SERVICES**

   a. JWCH agrees to provide recuperative care services in the form of transitional housing, meals, case management, nursing and primary medical care to homeless CLIENTS recovering from acute medical conditions treated at HOSPITAL who would benefit from recuperative care services from the distress of living on the streets. CLIENTS shall be referred to and linked with agencies especially skilled in delivering services to the homeless and shall be engaged to establish primary health care "home-base" clinic for on-going health care services to prevent CLIENTS from returning to the streets and lessen their use of the emergency department.

   b. JWCH shall evaluate and enroll any CLIENT that may qualify for SSI/SSA through a rapid process in conjunction with SSA and DHS, whereby a qualified person can receive Medicare/Medi-Cal benefits within one (1) to three (3) months instead of the usual six (6) or more months. Once SSI award has been received for the patient from HOSPITAL to JWCH, JWCH shall furnish HOSPITAL with the award notification so that HOSPITAL may pursue retrospective payment for services rendered by HOSPITAL to the client.

   c. HOSPITAL agrees to the conditions and criteria of referring CLIENTS to JWCH as described in JWCH's patient referral packet including, but not limited to, post hospital discharge **specialty care follow-up appointment(s), if necessary or until a JWCH provider deems necessary, any Durable Medical Equipment, 30-day supply of medication, 30-day supply of wound dressing, and full PT assessment for CLIENTS' ability to INDEPENDENTLY perform Activities of Daily Living (ADL) and TRANSFER him/herself from and to bed/toilet.**

   d. HOSPITAL shall establish a hospital staff and an alternate staff to interface with the JWCH Intake Coordinator.

e. DATA REPORTING – JWCH utilizes its own in-house database for CLIENT data collection. Data reporting to HOSPITAL shall be limited ONLY to JWCH's data collection and its standard reports unless otherwise agreed.

f. IV/Catheter Option.
CLIENTS with IVs and/or catheters shall be accepted in coordination with a home health care agency that supports serving the homeless population. This portion of services shall be performed by an agency designated by JWCH and billed by this home care agency directly to the HOSPITAL. The HOSPITAL acknowledges and fully agrees to be billed and submit payment(s) to the home health care agency as part of the conditions precendent to this agreement.

g. Physical Therapy (PT)/Occupational Therapy (OT) Option.
CLIENTS requiring PT/OT shall be accepted in coordination with an independent PT/OT agency working in conjunction with JWCH. This portion of services shall be performed by an agency designated by JWCH and billed by the PT/OT agency directly to the HOSPITAL. The HOSPITAL acknowledges and fully agrees to be billed and submit payment(s) to the home care/PT/OT agency as part of the conditions precedent to this agreement.

2. **INDEPENDENT JWCH -** Nothing in this Agreement shall construe JWCH or any of its employees or agents to be the employees, agents, or representatives of HOSPITAL. JWCH is a Federally Qualified Health Center and is a separate legal entity and shall have responsibility for and control over the recuperative care program operations described herein.

3. **COMPENSATION**
In consideration of the services rendered by JWCH during the period covered by this agreement, HOSPITAL hereby agrees to pay to JWCH in the following method:

1. Rate Calculation

i. Per day per bed rate of $_____ for each patient referred by HOSPITAL and accepted by JWCH.

ii. The total number of days for billing shall include admission date as a full day of Recuperative Care services. (As an example, The HOSPITAL shall be charged for 11 days if a CLIENT entered JWCH on January 1, 2014 and discharged on January 11, 2014.)

iii. The expected length of stay (ELOS) can be **estimated** by the HOSPITAL provider but **must be agreed upon by the JWCH provider**. Both the HOSPITAL's provider and JWCH's providers agree that some CLIENTS may require additional stay due to complications. See Section 4 for ELOS vs. Additional LOS.

iv. JWCH shall submit invoices to HOSPITAL monthly. JWCH's invoices shall reflect: JWCH's name; address; patient name and admission/discharge dates that correspond with patient(s) referred to JWCH. Original invoices shall be submitted to:

Entity:
Contact:
Title:
Address:
City, State and Zip Code:

4. **Expected LOS vs. Additional LOS (extension request)**
In the event the CLIENT requires additional days at JWCH, JWCH shall provide a request for additional days. However, if the HOSPITAL does not accept this request for additional days, the HOSPITAL agrees and understands to accept the CLIENT back to their hospital and further understands that JWCH shall transport the patient back HOSPITAL's emergency room at the HOSPITAL's expense. The HOSPITAL has 24 hours to respond to the extension request. A non-response to the extension request shall operate as a denial by JWCH and a refusal of the extension request. JWCH shall then return the CLIENT back to the HOSPITAL as described herein above.

5. **TERM** - This Agreement shall be in force and in effect for one (1) year from the date of execution. Both parties retain its rights to renew this Agreement annually in writing thirty (30) days prior to its expiration date. Furthermore, both parties retain the rights to end this agreement at any time with a sixty (60)-day advance written notice.

6. **TERMINATION** - If either party fails to comply with the terms and conditions of this Agreement, the other party may immediately suspend or terminate this Agreement. JWCH may terminate this Agreement, without cause, upon giving thirty (30) days written notice of intent to terminate to HOSPITAL. HOSPITAL may terminate this Agreement, without cause, at any time upon thirty (30) days written notice to JWCH. JWCH shall provide HOSPITAL with a final invoice for services within 45 days of termination and the last payment from HOSPITAL shall be due upon receipt.

7. **CONFLICT OF INTEREST** - HOSPITAL represents and warrants that there exists no actual or potential conflict of interest between its performance under this Agreement and its engagement or involvement in any other personal or professional activities. In the event such conflict or potential conflict arises during the term of this Agreement, or any extension thereof, HOSPITAL shall immediately advise JWCH thereof.

9. ENTIRE AGREEMENT. This Agreement, including the Intake Application, Referral, Medication Reconciliation, Public Communicable Disease Disclosure and Verification of Homelessness documents, sets forth the entire agreement between the parties relative to the subject matter hereof. No representation, promise or condition, whether oral or written, not incorporated herein shall be binding upon either party to this Agreement. No waiver, modification or amendment of the terms of this Agreement shall be effective unless made in

writing and signed by an authorized representative(s) of the party sought to be bound thereby.

_____ _____

Authorized Representative
Name:
Title:
Hospital Name:
Address:
City, State and Zip Code:

Date

_____ _____

Name: Al Ballesteros
Title: Chief Executive Officer
Address: JWCH INSTITUTE, INC.
5650 Jillson Street
Commerce, CA 90040

Date

Appendix 1

Section 1. Insurance; Risk of Loss

JWCH will maintain insurance policies reasonably required by HOSPITAL sufficient to protect against all applicable risks. Unless otherwise agreed, JWCH shall carry a minimum of $1 million of general and professional liability coverage at all times during the term of this Agreement. JWCH will provide HOSPITAL with certificates of insurance and other supporting materials as HOSPITAL may reasonably request to evidence JWCH's continuing compliance with these insurance requirements.

Section 2. Confidentiality of Patient Records.

The JWCH agrees to hold all individually identifiable patient health information ("Protected Health Information") that may be shared, transferred, transmitted, or otherwise obtained pursuant to this Agreement strictly confidential, and provide all reasonable protections to prevent the unauthorized use or disclosure of such information, including, but not limited to the protection afforded by applicable federal, state and local laws and/or regulations regarding the security and the confidentiality of patient health care information. JWCH further agrees to make every reasonable effort to comply with any regulations, standards, or rules promulgated pursuant to the authority of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), including those provisions listed below. The JWCH may use and disclose Protected Health Information when necessary for JWCH's proper management and administration (if such use or disclosure is necessary), or to carry out the JWCH's specific legal responsibilities pursuant to this Agreement. Specifically, the JWCH agrees as follows: (1) to maintain administrative, physical, and technical safeguards as necessary to ensure that the Protected Health Information is not used or disclosed except as provided herein and to protect the confidentiality, integrity, and availability of Protected Health Information; (2) to mitigate, if possible, any harmful effect known to JWCH of a use or disclosure of Protected Health Information by JWCH; (3) to ensure that any subcontractors or agents to whom it provides Protected Health Information will agree to the same restrictions and conditions that apply with respect to such information; (4) to make available respective internal practices, books and records relating to the use and disclosure of Protected Health Information received from HOSPITAL to the Department of Health and Human Services or its agents; (5) to incorporate any amendments or corrections to Protected Health Information when notified by HOSPITAL that the information is inaccurate or incomplete; (6) to return or destroy all Protected Health Information received from HOSPITAL that JWCH still maintains in any form and not to retain any such Protected Health Information in any form upon termination or expiration of this Agreement, if feasible or, if not feasible, JWCH agrees to limit any uses of Protected Health Information after this Agreement's termination or expiration to those specific uses or disclosures that make it necessary for JWCH to retain the information; (7) to ensure applicable policies are in place for providing the Protected Health Information to HOSPITAL to satisfy an individuals' request to access their information; (8) to report to HOSPITAL any use or disclosure of Protected Health Information which is not provided

for in the Agreement, to report unsuccessful security incidents to HOSPITAL upon request, and to report any successful security incidents to HOSPITAL; and (9) to make Protected Health Information available to HOSPITAL as requested to provide an accounting of disclosures to an individual who is the subject of the information, to the extent required by HIPAA. If at any time after the effective date of this Agreement it is determined that JWCH is in breach of this Section, HOSPITAL, in its sole discretion, may immediately terminate this Agreement. JWCH further agrees to sign any other documents, as appropriate, including but not limited to a Business Associate Agreement with HOSPITAL, if requested to do so by HOSPITAL.

Section 3. Access to Books and Records

During the term of this Agreement and for a period of four years after the termination hereof, JWCH shall grant access to the following documents to the Secretary of the U.S. Department of Health and Human Services ("Secretary"), the U.S. Comptroller-General and their authorized representatives: this Agreement, and all books, documents and records necessary to verify the nature and costs of services provided hereunder. If JWCH carries out the duties of this Agreement through a subcontract worth Ten Thousand Dollars ($10,000) or more over a twelve (12) month period with a related organization, this subcontract shall also contain a clause permitting access by the Secretary, Comptroller-General and their authorized representatives to the related organization's books, documents and records.

Section 4. Medicare/Medicaid Participation

JWCH hereby represents and warrants that neither JWCH nor its principals (if applicable) are presently debarred, suspended, proposed for debarment, declared ineligible, or excluded from participation in any federally funded health care program, including Medicare and Medicaid. JWCH hereby agrees to immediately notify HOSPITAL of any threatened, proposed, or actual debarment, suspension or exclusion from any federally funded health care program, including Medicare and Medicaid. In the event that JWCH is debarred, suspended, proposed for debarment, declared ineligible or excluded from participation in any federally funded health care program during the term of this Agreement, or if at any time after the effective date of this Agreement it is determined that JWCH is in breach of this Section, this Agreement shall, as of the effective date of such action or breach, automatically terminate. JWCH further understands that HOSPITAL periodically checks contracted individuals and entities against the Office of Inspector General (OIG) and General Service Administration (GSA) databases of Excluded Individuals and Entities and will notify JWCH if it discovers a match. HOSPITAL will take reasonable measures to verify that the match is the same individual or entity before taking any action to terminate any underlying agreement(s).

wesley Health Centers

You ARE INVITED...

April 7, 2015

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Dear Community Partner,

You are invited to JWCH Institute, Inc.'s ***Recuperative Care Information Session***, set to take place on Thursday - April 16, 2015. This invitation-only event brings together hospital representatives from our community to hear a presentation of JWCH's Recuperative Care services, our accomplishments, challenges, admissions process and the impact our Recuperative Care has in the community.

This presentation will be held at the JWCH Corporate Office located at 5650 Jillson Street, Commerce, CA 90040 from 12:30 pm—1:30 pm. Lunch will be provided to all of our guests.

We hope that you can join us for this presentation. We appreciate your support as we work together to keep our communities stronger and healthier.

Our Recuperative Care program provides a safe place for homeless people to complete their recovery after a hospital stay. Without Recuperative Care, many homeless patients would go straight from a hospital bed to the street, without any means to clean wounds, keep medications safe, or get the rest they need to avoid a relapse.

To RSVP for this event, please contact Chris Oropeza to 323-201-4516 Ext: 3018 no later than Monday - April 13, 2015.

Your attendance is appreciated.

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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 30 beds at Salvation Army Bell Shelter . Recuperative Care provides 24 hours a day bed for each residents and provides 24 hours nursing care. Although there is 24-hours 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 Coordinator at (323) 263.8840. 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 (323) 263.8348.

What happens next?

Click highlighted txt BELOW for tracking log

Once the Provider Referral Form is received, the on-call Recup Provider will determine if the patient meets the Recuperative Care admission criteria. S3: C-3 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 of acceptance into the program and determine the placement location. The Intake Coordinator will then arrange the date/time for Recup admission and arrange for patient transporation if available. S3: C-5 If beds are unavailable, accepted patients will be placed on a waiting list. Daily updates of bed availability will be communicated to the referring agency by the Intake Coordinator.

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

5600 Rickenbacker Rd.
Building 1-E
Bell, CA. 90201
Phone: 323.263.8840
Fax: 323.263.8348

Of note:

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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.**

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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

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- 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

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- 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

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RECUPERATIVE CARE REFERRAL TRACKING LOG & WAIT LIST — MONTH / YEAR: Jul-13 — UPDATED TO: (see summary at end of log)

	REFERRAL SOURCE		MORNING CENSUS / BED AVAILABILITY [Per Day of Referral]		INITIAL REFERRAL PACKET RECEIVED BY JWCH		INITIAL REFERRAL RESPONSE TO DHS		REFERRAL PROCESSING			INTAKE RESULTS						NOTIFICATION TO DHS		RC ADMISSION			
Patient Name	DHS Facility/ Managed Care	Name of Referring Party	DHS Census (Morning)	# of Available Beds (Morning)	Date	Time	Date	Time	Additional Items Needed (use codes below)	Date Received All Items (Intake Packet Completed)	Time	Date Referral Accepted	Was Patient Put on Wait List?	Wait List Reason (use codes)	Wait List Order (Subject to Change)	Date of Denial	Reason for Denial (use codes)	Date	Time	Date	Time	RC Site (BS or WC)	Comments / Notes
REFERRAL(S) FROM PREVIOUS MONTH(S) CARRIED OVER:																							
Doe, Fernando	RLA	Cesar Robles			5/8/13	1:19 PM	5/8/13	1:42 PM	8	Pending													5/15/13 unstable psy. Condition pending update.
brudo, benjamin	LAC/USC	Yen Saw			6/7/13	10:55 AM	6/7/13	12:07 PM	N/A	6/7/13	10:55 AM	6/7/13	YES	1	N/A	N/A	N/A	6/7/13	1:45 PM	07/06/13	11:00 AM	BS	
Doe, Sheila	LAC/USC	P. Delgado			6/25/13	1:03 PM	6/25/13	2:14 PM	10,15	PENDING													6/25/13 pending requested updates.
Doe, Bryan	RLA	Cesar Robles			6/25/13	2:00 PM	6/25/13	2:58 PM	N/A	6/25/13	2:00 Pm	6/25/13	No	N/A	N/A	N/A	N/A	6/25/13	3:00 PM	N/A	N/A	N/A	6/28/13 pt is not cleared by OT per sw. 7/9/13 pt scheduled to go to bell. 7/30/13 pt left hospital AMA
REFERRAL(S) FROM CURRENT MONTH:																							
Doe, Jeisler	HUCLA	Melissa Banuelos			7/11/13	12:56 PM	7/11/13	4:06 PM	N/A	7/11/13	12:56 PM	N/A	N/A	N/A	N/A	7/11/13	3	7/11/13	4:15 PM	N/A	N/A	N/A	
Doe, chris	OVMC	Fred Schwab			7/12/13	9:10 AM	7/12/13	9:42 AM	10,15	Pending		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	7/12/13 per se pt was dc sober living.
Doe, Hamid	LAC/USC	Jimmy Mar			7/12/13	2:52 PM	7/15/13	10:17 AM	N/A	7/12/13	2:52 PM	7/15/13	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	7/15/13 per sw pt left the hospital on Saturday 7/13/13.
Doe, Anthony	DHS	DHS manged care			7/12/13	9:50 AM	7/15/13	10:04 AM	12,15	7/15/13	9:50 Am	7/15/13	No	N/A	N/A	N/A	N/A	7/15/13	11:00 AM	07/15/13	3:00 PM	BS	
Doe, Vicky	HUCLA	Cecila Coroy			7/15/13	3:18 PM	7/15/13	3:49 PM	9,10,15	Pending													
Doe, Louis	RLA	Ceasar Robles			7/16/13	9:00 AM	7/16/13	2:00 PM	N/A	7/16/13	9:00 Am	7/16/13	Yes	N/A	N/A	N/A	N/A	7/16/13	2:15 PM	08/02/13			7/29/13 Pending possible bed at PATH
Doe, David	LAC/USC	Eddie Klien			7/16/13	10:15 AM	7/16/13	2:15 PM	N/A	7/16/13	10:15 AM	7/16/13	No	N/A	N/A	N/A	N/A	7/16/13	2:30 PM	07/17/13	4:00 PM	BS	
Doe, Salvador	LAC/USC	Amy McCorrmick			7/17/13	10:19 AM	7/17/13	10:28 AM	10,15	7/17/13	2:57 PM	7/17/13	No	N/A	N/A	N/A	N/A	7/17/13	3:00 PM	07/18/13	2:20 PM	BS	
Doe, Edward	HUCLA	Melissa Banuelos			7/17/13	10:50 AM	7/17/13	11:13 AM	10,15	7/18/13	2:24 PM	7/18/13	No	N/A	N/A	N/A	N/A	7/18/13	2:25 PM	07/20/13	11:00 AM	BS	
Doe, Bradley	OVMC	Judith Winters			7/18/13	11:15 AM	7/18/13	2:00 PM	N/A	7/18/13	11:15 AM	7/18/13	No	N/A	N/A	7/19/13	1	7/18/13	2:15 PM	N/A	N/A	N/A	7/19/13 provider decided t re-review refereal, pt was denied.
Doe, Joseph	LAC/USC	Yvonne Delgado			7/18/13	112:00 PM	7/18/13	2:15 PM	N/A	7/18/13	12:00 PM	7/18/13	No	N/A	N/A	N/A	N/A	7/18/13	2:30 PM	07/19/13	4:00 PM	BS	
Doe, Alba	LAC/USC	Enrique Diaz			7/19/13	9:00 AM	7/19/13	12:45 PM	10,15	7/26/13	1:29 PM	7/26/13	No	N/A	N/A	N/A	N/A	7/26/13	1:35 PM	N/A	N/A	N/A	7/30/13 per sw pt dc-ed 7-29 to shelter

	Doe, Steve	LAC/USC	Yvonne Delgado			7/19/13	8:59 AM	7/19/13	11:56 AM	N/A	7/19/13	8:59 Am	7/19/13	N0	N/A	N/A	N/A	N/A	7/19/13	12:00 PM	07/19/13	3:30 PM	BS	
	Doe, Rosario	HUCLA	Palacios			7/19/13	10:15 AM	7/19/13	12:18 PM	N/A	7/19/13	10:15 Am	N/A	N/A	N/A	N/A	7/19/13	1	7/19/13	1:00 PM	N/A	N/A	N/A	dc-ed 7-21 to shelter
	Doe, Maryanne	LAC/USC	Yvonne Delgado			7/19/13	12:10 PM	7/19/13	12:28 PM	N/A	7/19/13	12:10 Pm	7/19/13	N/A	N/A	N/A	N/A	N/A	7/19/13	1:15 PM				
	Doe, Cristobal	HUCLA	Maria Lebia			7/19/13	8:52 AM	7/19/13	1:43 AM	15	7/24/13	2:17 PM	7/24/13	Yes	N/A	N/A	N/A	N/A	7/24/13	2:30 PM	08/02/13			7-30-13 pt needs blood transfusion not ready for dc
	Doe, Juan	HUCLA	Melissa Banuelos			7/23/13	9:00 AM	7/23/13	1:00 PM	N/A	7/23/13	9:00 Am	7/23/13	N/A	N/A	N/A	N/A	N/A	7/23/13	1:40 PM	N/A	N/A	N/A	7-30-13 not ready for admission per sw, 8/1 pt will not be coming
	Doe, Raffael	LAC/USC	Michelle Whang			7/23/13	11:00 PM	7/23/13	1:20 PM	N/A	7/23/13	11:00 AM	7/23/13	yes	N/A	N/A	N/A	N/A	7/23/13	2:00 PM	07/30/13	1:00pm	BS	7/30/13 pt arrived and left AMA
	Doe,Jose	LAC/USC	Jimmy Mar			7/23/13	12:15 PM	7/23/13	1:35 PM	N/A	7/23/13	12:15 PM	7/23/13	yes	1	N/A	N/A	N/A	7/23/13	2:15 PM	07/26/13	3:00 PM	BS	
	Doe, Robert	LAC/USC	Marisa Orozco Tapia			7/24/13	4:22 PM	7/24/13	5:12 PM	N/A	4/22/13	4:22 PM	7/24/13	Yes	N/A	N/A	N/A	N/A	7/25/13	10:00 AM	07/31/13	4:00pm	BS	7-30-13 not ready for dc today, possibly tomorrow
	Doe, Gregory	HUCLA	JC Garcia			7/25/13	10:15 AM	7/25/13	2:40 PM	10,15	7/31/13	2:25 Pm	7/31/13	YEs	1	N/A	N/A	N/A	7/31/13	2:30 PM				
	Doe, Leo Roberto	HUCLA	Maria Lebia			7/25/13	10:30 AM	7/25/13	2:45 PM	15	7/30/13	2:00 Pm	7/30/13	Yes	1	1	N/A	N/A	7/30/13	1:15 PM				
	Doe, Adrine	OVMC	Yvette Cardenas			7/25/13	11:00 AM	7/25/13	3:00 PM	15	7/26/13	1:51 PM	7/26/13	Yes	2	N/A	N/A	N/A	7./26/13	2:00 PM	N/A	N/A	N/A	7/29/13 pt decided to stay with family.
	Doec, mark Anthony	HUCLA	Hasmik			7/25/13	2:45 PM	7/26/13	4:01 PM	9,10,15	Pending													
	Doe, John	LAC/USC	Marisa Orozco Tapia			7/26/13	9:30 AM	7/26/13	1:59 PM	10,14,15	7/31/13	9:27 MA	7/31/13	yes	1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	discharged on 8-5-13
	Doee, Blair	LAC/USC	Fines			7/26/13	2:51 PM	3/1/13	3:45 PM	N/A	3/26/13	2:51 PM	N/A	N/A	N/A	N/A	N/A	7/26/13	1	7/26/13	3:50 PM	N/A	N/A	N/A	
	Doe, Brandon	LAC/USC	Carin Stinson			7/26/13	3:02 PM	7/26/13	3:51 PM	N/A	3/26/13	3:02 Pm	N/A	N/A	N/A	N/A	N/A	7/26/03	5	3/26/13	4:00 PM	N/A	N/A	N/A	
	Doe, Martin	RLA	Christina C			7/26/13	3:35 PM						N/A	N/A	N/A	N/A	N/A	7/30/13	1	7/30/13	3:00 PM	N/A	N/A	N/A	
	Doe, Malaika	DHS manged care	DHS manged care			7/26/13	12:21 PM	7/26/13	3:27 PM	10	7/29/13	12:29 Pm	7/29/13	Yes	2	N/A	N/A	N/A	7/29/13	1:00 PM	07/31/13	3:15 PM	BS	
	Doe, John	LAC/USC	kim ly Hyunh			7/29/13	10:39 AM	7/29/13	12:11 PM	10,15	Pending													
	Doe, Robert	RLA	Steven Baffa			7/29/13	11:38 AM	7/29/13	12:33 PM	10,15	7/31/13	10:24 Am	7/31/13	yes	1	3	N/A	N/A						
	Doe, Daryl Johnsoncc	HUCLA	Melissa Banuelos			7/29/13	11:35 AM	7/29/13	12:00 PM	10,15	7/30/13	2:00 PM	7/30/13	Yes	1	2	N/A	N/A	7/30/13	2:15 PM				
	Doe, Matthew	LAC/USC	Yvonne Delgado			7/29/13	2:01 PM	7/29/13	3:46 PM	N/A	7/29/13	2:01 PM	7/29/13	Yes	1	N/A	N/A	N/A	7/29/13	3:46 PM	07/31/13	4:30 PM	BS	
	Doe, Micheal	LAC/USC	Amy McCorrmick			7/30/13	11:11 AM	7/30/13	1:30 PM	N/A	7/30/13	11:11 AM	N/A	N/A	N/A	N/A	N/A	7/30/13	1	7/30/13	1:45 PM	N/A	N/A	N/A	
	Doe, Eric	HUCLA	Hasmik			7/31/13	2:45 PM	7/31/13	10:53 PM	10,15	Pending													
	Doe, Guillermo	LAC/USC	P. Delgado D,			7/31/13	10:30 AM	7/31/13	10:56 AM	15	Pending													
	Doe, John	OVMC	Fred Schwab			7/31/13	2:44 PM	7/31/13	10:39 PM	15	Pending													

As Of 7/31/13 @4:30 PM

Census & Avail. Beds:	31	3

Referrals Pending/ Need Additional Info:	8

Completed Referrals Pending Approval:	0

3	: Approved Referrals On Wait List

3	: Scheduled for Admission

LEGEND/CODES:

CONSULTATION, ADDITIONAL INFO OR MEDICAL CLEARANCE CODES:		
1 - Cardiology	7 - Orthopedic	13 - Medication List for
2 - Epidemiology	8 - Psychiatry	14 - Other: H&P Prog r
3 - Hematology	9 - OT/PT	15 - Other : _____
4 - Infectious Disease	10 - Labs	16 - Other : _____
5 - Neurology	11 - Home Health Order	
6 - Neurosurgery	12 - Follow-Up Appt	

Legend for Wait List	NON-ACCEPTANCE / DENIAL CODES:	
1 - No Bed Avail	1 - Chronic condition, no acute med. neec	7 - Previous non-compliance/Rule Violatior
2 - Needs Female Bed	2 - Not cleared by PT	8 -
3 - Needs Male Bed	3 - Requires higher LOC	9 -
4 - Needs Bed at Bell	4 - DHS MD recommended SNF/Higher LOC	10 - Other: _____
5 - Needs Bed at WC	5 - Not stable mental health	11 - Other: _____
On WL as of rept date	6 - Not stable medical condition	12 - Other: _____

JWCH RECUPERATIVE CARE
January 2015 **DHS REFERRALS DENIED**

	Date Denied	Referring DHS Facility	Patient Name	Reason for Denial
1	1/2/2015	HUCLA	Doe, Jacobo	**Denied 1-02-15** Chronic ongoing condition with no endpoint in care. Pt with cirrhosis with multiple hospital admission for confusion 2/2 hepatic encephalopathy on 07-25-14, 10-22-14, 11-22-14 and again now 11-26-14 due to continued drinking and medication non-compliance.
2	1/2/15	LAC/USC	Doe, Aaron	**Denied 01-02-15** paraplegia needing bedside nursing care, wound is chronic and will require longterm care Unstable psych condition with intermittent SI with past failed suicidal attempts x 2
3	1/6/15	LAC/USC	Doe, Jose	**Denied 01-06-14** Fall risk, multiple prior falls resulting in hospital admissions. Reason for fall is still unclear. Patient requires closer supervision than what Recup can provide Pt requires IV abx Q4 hours for emperic treatment of neurosyphilis, given his mentation, he will not be able to self infuse. Homehealth nurse will not be able to return to facility Q4 hrs for multiple infusions Patient lives with sister – not homeless
4	1/6/15	LAC/USC	Doe, Javier	**Denied 01-06-15:** Patient with ESRD and failed to keep dialysis appts missed 2 weeks of dialysis Conditions are chronic and ongoing with no end point of care.
5	1/8/15	HUCLA	Doe, Sidney Michael	**Denied 01-08-15** **1) Condition is chronic and progressive with no end point in care. PT declines chemo**
6	1/12/15	LAC/USC	Doe, Michael	**Denied 01-12-15** 1) Psych disorder with recent failed suicidal attempt. Need closer supervision than what Recup can provide
7	1/14/15	HUCLA	Doe, Barry	**Denied 01-12-15** All reasons for referral are for chronic conditions. He does not have acute need for Recup.
8	1/22/15	LAC/USC	Doe, Emilio	**Denied 01-22-15** 1) Pt who drinks daily, uses crutches and who will need to be on blood thinner will require closer supervision that what Recup can provide
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JWCH RECUPERATIVE CARE
February 2015 **DHS REFERRALS DENIED**

	Date Denied	Referring DHS Facility	Patient Name	Reason for Denial
1	2/3/15	LAC/USC	Doe, Alfonse	**Denied 02-03-15, delayed response x 1 day, provider not in Recup yesterday afternoon and today in AM** Pt is referred for a chronic and progressive condition Admitted on 5150 for grave disability. GI assessed patient and determined that patient is not consent able d/t his mentation. He will likely not be able to self care/take his own meds while in Recup.
2	2/5/15	LAC/USC	Doe, Nora	**Denied 02-05-15** 1) Pt has had multiple unsuccessful admissions at Recup due to failure to self care: from her inability to self care for her colostomy bag with stool leakage all over the facility and her bed to being disruptive to care of other patients: inconsolable crying throughout the day and night disrupting rest of her fellow roommates and poor cooperation with her medical care. Additionally, she is not reliable to take her own psychiatric meds nor any other medication for that matter. She requires a program that can provide more closer supervision and assistance
3	2/5/15	LAC/USC	Doe, Gregory	**Denied 02-05-15** 1) Pt is a paraplegic man with chronic sacral decub ulcers since '08. Wound is chronic in nature and pt will require bedside nursing care which Recup is unable to provide. Pt was previously residing at Longwood Manor and per hosp note is agreeable to accept patient back if referred by hosp.
4	2/6/15	HUCLA	Doe, Demetria	**Denied 02-06-15** 66yo woman with intermittent AMS (altered mental status) with MULTIPLE pending/unresolved issues: Large ovarian mass likely malignancy still awaiting surgery Sepsis with fevers still yesterday and WBC still 20.6 as of 02-06-15 Intermittent hypokalemia Persistent hypercalcemia Gross hematuria – etiology still unclear (thought not to be 2/2 stones although pt does have stones), nephrolithiasis with B hydronephrosis Continued urine leakage from foley CXR with R upper lobe nodule 6mm But pt is ready to be discharged from hospital???
5	2/11/15	LAC/USC	Doe, Ramon	**Denied 02-12-15** Pt is s/p major cardiac surgery only 2 days ago, should be further monitored as an inpatient for now LFT has worsened. AST/ALT = 164/128 on 02-11-15. NOW 764/360 T bili 2.6 as of 02-12-15 WBC uptrending Pneumothorax still with chest tube Currently requires 1:1 monitoring/supervision and assistance during meals 2/2 or concerns for aspiration Still CGA with FWW per PT notes 02-11-15, even sit to stand requires supervision at this time
6	2/12/15	LAC/USC	Doe, George	**Denied 02-12-15** Pt has SI with past failed suicidal attempts Per hospital notes pt has had 7 Auto vs. Ped accidents Pt endorsed to Chaplin that he feels a "deep sense of despair and hopelessness" per notes 02-06-15
7	2/17/15	LAC/USC	Doe, Lena	**Denied 02-17-15** Still having significant cough/congestion as of note 02-15-15 and noted reparatory distress last night 02-17-15 Pt continues to wheeze, labored breathing even after breathing treatments per note 02-15-15 Still needs assistance while walking with walker Pt should be transferred to SNF for closer monitoring/higher level of care
8	2/18/15	LAC/USC	Doe, George	**Denied 02-18-15** 1) Pt is paraplegic and will require bedside nursing care for decub ulcers. 2) Decub ulcers are typical chronic
9	2/24/15	HUCLA	Doe, Demetria	**Denied 02-06-15, denied 02-24-15** Pt with ovarian CA with mets to bladder. Pt is not surgical candidate and has refused future treatment with chem/radiation. Condition is chronic and progressive

February 2015 **DHS REFERRALS DENIED**

	Date Denied	Referring DHS Facility	Patient Name	Reason for Denial
10	2/24/15	HUCLA	Doe, Moises	**Denied 02-24-15** Pt with clear cell renal cell carcinoma s/p L nephrectomy now with metastasis to bladder and lungs (several lung nodules) and supraclavicular nodes. Pt too frail for further treatment per notes. Condition is chronic and progressive with no end point in care Suggest SNF for this patient.
12				

LEASE AGREEMENT

This Lease is made as of January 1, 2012, between The Salvation Army, a California corporation ("Landlord') and JWCH Institute, Inc., a non-profit organization ("Tenant"), whose address is 1910 W. Sunset Boulevard, Suite 650, Los Angeles, CA 90026.

1. DEFINITIONS. The following terms used in this Lease shall have the meanings set forth below.

1.1 Base Rent/Fees: $29,041 per month for months 1 – 12 and $29,041 for months 13 – 24.

1.2 Brokers: None.

1.3 Commencement Date: January 1, 2012.

1.4 Expiration Date: December 31, 2014.

1.5 Parking: Tenant shall be entitled to a reasonable number of parking privileges in the parking area adjacent to the Premises, as reasonably determined by the Landlord from time to time, without paying any additional rent. Such parking spaces shall not be reserved and shall be used in-common with other tenants of the Project. Tenant's parking shall be limited to vehicles no larger than standard size automobiles or pickup utility vehicles. Unless otherwise stipulated by Landlord in writing, Tenant shall not cause large trucks or other large vehicles to be parked within the project or on the adjacent public streets. Temporary parking of large delivery vehicles in the Project may be permitted by the rules and regulations established by Landlord.

1.6 Project: The Project is a development formerly known as the Bell Federal Service Center as described on Exhibit "A-1" (the "Project"). The Project includes Building 1 (Bays A, B, C, D and E) and Building 2 (Bays A, B, C, D and E) and the road, parking access and real property, located at 5600 Rickenbacker Road, Bell, CA 90201-6418

1.7 Premises: The Premises is that portion of the Property that contains approximately 6,889 square feet, located in Bay E of Building 1, and shown (grey area) on the floor plan attached hereto as Exhibit "A-2" (the "Premises").

1.8 Security Deposit: Not applicable.

1.9 Tenant Improvements: Tenant shall accept the Premises in its "as-is" condition. Any tenant improvements that physically alter the Premises must be approved in writing in advance by Landlord.

1.10 Use: Tenant shall use and occupy the Premises solely and exclusively for services eligible under Title V of the Stewart B. McKinney Homeless Assistance Act. Specific use of the Premises is for the operation of a 30-bed Recuperative Bed Program for homeless adults released from local hospitals who require limited medical attention and emergency shelter.

2. EXHIBITS. The following exhibits are attached to and made a part of this Lease:

Exhibit "A-1" and Exhibit "A-2"

3. LEASE. Landlord leases to Tenant the Premises, and Tenant leases the Premises from Landlord, subject to the terms and conditions of this Lease. Tenant accepts the Premises in "as is" condition, and acknowledges that Landlord makes no representation or warranty, express or implied in fact or by law, as to the condition of the Premises. The Lease term ("Term") shall begin on the Commencement Date and end on the Expiration Date unless sooner terminated pursuant to the provisions of this Lease.

4. USE. Tenant shall use the Premises, at all times during the Term, for the Use and for no other use or purpose. Except as otherwise provided in this Lease, Tenant's quiet enjoyment of the Premises during the Term shall not be disturbed by any act of Landlord, or of anyone acting through or under Landlord, so long as no Event of Default by Tenant shall have occurred and Tenant shall have fully performed all of the terms of this Lease. Tenant shall, at its cost, fully comply with all laws, statutes, codes, rules, regulations, ordinances, orders, judgments, decrees, writs, permits, certificates, licenses, or other authorizations, directions or requirements ("Legal Requirements") of any domestic or foreign, federal, state, county, municipal, or other government or governmental or quasi-governmental department, commission, board, bureau, court, agency, or instrumentality having jurisdiction or authority over Landlord, Tenant, and/or all or any part of the Premises ("Legal Authority"). Tenant shall not do or permit any act to be done or to exist upon the Premises, which may (a) be dangerous, unless safeguarded as provided for by Legal Requirements; (b) constitute a public or private nuisance; or (c) make any insurance void or voidable or cause any increase in insurance premiums. Tenant shall neither cause nor permit the Premises to be used to generate, manufacture, refine, transport, treat, store, handle, dispose, transfer, produce, or process Hazardous Materials, except in compliance with all Legal Requirements; neither cause nor permit a release or threatened release of Hazardous Materials onto the Premises or any other property as a result of any intentional or unintentional act or omission on the part of Tenant; comply with all applicable Legal Requirements related to Hazardous Materials; and cooperate with Landlord in compliance with Legal Requirements in regard to the Building including but not limited to any upgrading of life safety systems or removal of asbestos, it being acknowledged that the Building may not have all systems and improvements which would be required if the Building were newly constructed as of the date of this Lease. Tenant shall faithfully observe and comply with rules and regulations as promulgated by Building management from time to time. Landlord shall not be responsible for the nonperformance by others of any of such rules and regulations. "Hazardous Materials" are defined as any flammable explosives, radioactive materials, oil or petroleum products and their by products, asbestos, polychlorobiphenyls, hazardous materials, hazardous wastes, hazardous or toxic substances, or related materials as defined under or regulated by any Legal Requirements, including, without limitation, the following statutes and the regulations promulgated under their authority: (a) the Comprehensive Environmental Response, Compensation, and Liability Act of 1980, as amended (42 U.S.C. §§ 9601 et seq.); (b) the Hazardous Materials Transportation Act, as amended (49 U.S.C. §§ 1801 et seq.); and (c) the Resource Conservation and Recovery Act of 1976, as amended (42 U.S.C. §§ 6901 et seq.).

5. **RENT/FEES**. Tenant shall pay Base Rent/Fees and all sums due under this Lease (together, "Rent/Fees") with applicable tax when due, without notice or demand, at Landlord's office in the Building or as instructed by Landlord ("Place of Payment"). Base Rent/Fees are payable monthly in advance on or before the first of each calendar month during the Term (prorated for partial months, if any). Other sums shall be paid upon notification by Landlord. If payment is not received when due, an administrative fee and late charge of Two Hundred Fifty Dollars ($250.00) shall be immediately due and payable without notice or demand. This provision is not a grace period; it is not a penalty, but liquidated damages to defray administrative and related expenses. An additional administrative fee and late charge shall become immediately due and payable on the first of each month for which any portion of a payment (or administrative fee and late charge) remains unpaid, and for processing of any check returned unpaid. Tenant acknowledges that Rent payments shall be made by Tenant to Landlord without any claim on the part of Tenant for diminution, setoff, or abatement. Nothing shall suspend, abate, or reduce any Rent.

6. **SECURITY DEPOSIT**. Not Applicable.

7. **SERVICES**. **a)** No electric current shall be used except as provided by Landlord; no electric cable or wire shall be brought into the Premises except with Landlord's prior written consent. Tenant shall not use machines that use more than standard current or which shall overload the Building's circuits. Parking shall be provided as described in 1.5.

b) In addition, Landlord agrees to provide Tenant with the following **ADDITIONAL SERVICES**: security and maintenance/janitorial services, client meals (3 daily), utilities, and client transportation.

8. **CONDITION OF PREMISES**. Tenant shall not, without Landlord's prior consent that may be granted or withheld in Landlord's sole discretion, paint, install window treatment, hang shelves or paintings or otherwise alter the Premises. Tenant may not install signs within or without the Premises that can be seen from any other part of the Building, or from outside the Building without prior written consent of Landlord, and Landlord may remove any sign for which written consent has not been granted. Landlord and Landlord's employees and other agents shall have the right, but not the obligation, upon reasonable notice to Tenant, and at reasonable times, to enter upon and pass through the Premises from time to time in order to (a) make an examination of the Premises, and (b) show the Premises to prospective purchasers, mortgagees, prospective mortgagees, and others, and (c) to provide the ADDITIONAL SERVICES described above. In the event of an emergency, Landlord and Landlord's agents shall have the right, but not the obligation, without any notice to Tenant, to take such actions, whether on or off the Premises, as Landlord shall deem appropriate to respond to the emergency. Tenant shall accept the Premises in its “as-is” condition.

9. **INSURANCE**. Tenant shall, at its own cost and expense, maintain commercial general liability insurance protecting against loss of life, bodily injury and property damage, any and all liability occasioned by negligence, occurrence, accident, or disaster with respect to the Premises and Tenant's operations thereon, with such insurable limits as Landlord may from time to time require, but in no event less than Two Million and No/100 Dollars ($2,000,000.00) combined single limit bodily injury and property damage liability on an occurrence basis with a Two Million and No/100 Dollars ($2,000,000.00) aggregate. Such insurance shall name Landlord as additional insured,

and be in amount and with an insurer acceptable to Landlord. Tenant shall provide a copy of the policy, or a binding certificate, to Landlord upon execution of this Lease.

10. INDEMNIFICATION. Tenant shall defend, indemnify and save harmless Landlord and its agents from and against any liability, loss, damages, expenses, costs, interest, settlements, fines, penalties, claims, demands, and judgments including attorneys' fees arising out of, or in any way related to (a) the presence, disposal, release, or threatened release, by or caused by Tenant or its agents, of any Hazardous Materials; (b) any personal injury or damage to property, real or personal related to such Hazardous Materials; (c) any lawsuit brought, threatened, or settled by Legal Authorities or other parties, or order by Legal Authorities, related to such Hazardous Materials; (d) any violation of Legal Requirements related in any way to such Hazardous Materials; (e) any injury or claim of injury during the Term to person or property of any nature, and any matter or thing, related to or connected with the Use and any other use, occupation, possession, management, operation, control, improvement, repair, maintenance, demolition, restoration, replacement, or rebuilding of all of any part of the Premises; (f) Tenant's failure to comply fully and promptly with all Legal Requirements; and/or (g) Tenant's failure to perform fully and promptly all of the terms and conditions of this Lease. If Tenant fails to comply with the terms of this Lease, Landlord may at its option, and in addition to its other remedies, effect such compliance in such manner as Landlord deems advisable and Tenant shall, on demand, reimburse Landlord's expenses related to such compliance. Landlord's undertaking such cure shall not obligate Landlord to complete it. Tenant shall reimburse Landlord upon demand for all reasonable expenses, including attorneys' fees, incurred by Landlord in connection with (a) any litigation or dispute in which Landlord becomes involved related to the Premises or this Lease (except to the extent Landlord is found to be at fault); (b) all costs of reletting the Premises in the event of Tenant's default, including brokers' charges, and the proportionate share of the original brokers' fees, if any, for which Tenant has not paid all Rent, and (c) the enforcement or collection of any judgments, settlements or court awards. If Tenant and Landlord are in litigation, the prevailing party shall be entitled to attorneys' fees from the non-prevailing party. In each instance when Tenant shall be obligated to make any payment of any sum under this Lease, interest shall accrue on such payment and shall be payable under this Lease at the highest rate permitted by applicable law.

11. CONSTRUCTION LIENS. Landlord's interest in the Premises shall not be subject to liens for improvements made by Tenant. No act or omission of Tenant shall give any person the right to file a construction or other lien against such interest without Landlord's prior written consent. Landlord shall not be liable for any work performed or to be performed on, or for any materials furnished or to be furnished at, the Premises for Tenant or any subtenant, and no construction, mechanic's or other lien for such work or materials shall attach to any interest of Landlord in the Premises. If, in connection with any work being performed for Tenant or any subtenant, or in connection with any materials being furnished to Tenant or any subtenant, any lien or charge shall be filed or made against the Premises or Landlord's interest in the Premises, then Tenant, at Tenant's cost and expense, shall immediately cause such lien or charge to be cancelled and discharged of record and satisfy and discharge any judgment entered in any proceeding. If Tenant fails to discharge any lien, charge, or judgment as required by this Section, Landlord may pay such item or discharge such liability by payment and/or bond. Such amounts as are so paid by Landlord, together with any incidental expenses, including attorneys' fees, shall be immediately due as additional Rent. Tenant shall notify any contractor making any improvements upon the Premises of the provisions of this Section before such contractor commences to make such improvements.

12. DAMAGE; EMINENT DOMAIN. If at any time during the Term any part of the Building shall be taken in the exercise of the power of eminent domain by any Legal Authority, or there shall be any damage to or destruction of a part of the Building, Landlord may cancel this Lease and shall not be obligated to rebuild the Building.

13. ASSIGNMENT; SUBLETTING. Tenant shall not in any manner make or allow any assignment, subletting, or occupancy arrangement or any encumbrance of the Premises or this Lease. Any attempt to do any of the foregoing without Landlord's prior written consent shall be void. A change in ownership of Tenant shall be deemed an assignment.

14. DEFAULT; REMEDIES.

14.1 An Event of Default shall occur if any payment to be made under this Lease is not made when due; if any obligation of Tenant is not timely performed or Tenant shall otherwise be in default of a provision of this Lease; or if Tenant shall be brought within the purview of a Bankruptcy Court, whether adjudicated a bankrupt or not.

14.2 If there is an Event of Default by Tenant, Landlord, at Landlord's option, may elect to do one or more of the following: (a) accelerate all of the remaining Rent for the Term, in which event all Rent shall become immediately due and payable; (b) terminate this Lease and re-enter the Premises and remove all persons and property from the Premises, by summary proceedings or by any other suitable action or proceeding at law, or otherwise; or, (c) without terminating this Lease, re-enter the Premises and remove all persons and property from the Premises, by summary proceedings or otherwise, and relet the Premises. If Landlord elects to terminate this Lease, Tenant shall quit and peacefully surrender the Premises to Landlord, without any payment by Landlord for doing so, on or before the effective date of termination, and all Rent shall be paid up to the effective date of termination, together with such expenses, including attorneys' fees, as Landlord shall incur in connection with such termination. No receipt of money by Landlord from Tenant after termination of this Lease shall reinstate, or extend the Term, affect any notice previously given by Landlord to Tenant, or operate as a waiver of the right of Landlord to enforce the payment of Rent. If Landlord shall terminate this Lease, Landlord shall be entitled to retain, free of trust, all sums then held by Landlord pursuant to any of the provisions of this Lease. In the event of any re-entry and/or dispossession by summary proceedings or otherwise without termination of this Lease, all Rent shall become due and shall be paid up to the time of such re-entry and/or dispossession, together with such expenses, including attorneys' fees, as Landlord shall incur in connection with such re-entry and/or dispossession by summary proceedings or otherwise; all Rent for the remainder of the Term may be accelerated and due in full; and Landlord may relet all or any part of the Premises, either in the name of Landlord or otherwise, for a term which may, at Landlord's option, be equal to, less than, or greater than the period which would otherwise have constituted the balance of the Term. Tenant shall pay, as additional Rent, to Landlord, as they are incurred by Landlord, such reasonable expenses as Landlord may incur in connection with reletting including, without limitation, attorneys' fees, brokerage commissions, and expenses incurred in altering, repairing, and putting the Premises in good order and condition and in preparing the Premises for reletting. If Tenant shall not have paid accelerated Rent, Tenant shall pay in monthly installments on the due dates for Rent payments for each month of the balance of the Term, the amount by which any Rent payment exceeds the net amount, if any, of the rents for such period collected on account of the reletting of the Premises; any suit brought to collect such amount for any months shall not prejudice in

any way the rights of Landlord to collect the deficiency for any subsequent months by a similar action or proceeding. Landlord shall have as Landlord's absolute property, any sums collected by Landlord upon reletting the Premises after Landlord shall resume possession of the Premises including, without limitation, any amounts by which the sums so collected shall exceed the continuing liability of Tenant under this Lease. If Landlord shall have accelerated and collected Rent payments and subsequently shall have relet the Premises, then Landlord, after deducting all costs related to reletting shall pay to Tenant the amount remaining which is collected as Rent for each month, to the extent Landlord shall have previously received the Rent for such month from Tenant.

15. RELOCATION. Landlord may relocate Tenant to another location in the Building, without releasing Tenant of any obligation under this Lease for the full Term. If Landlord remodels a substantial portion of the Building and deems the Premises to be needed for other purposes than this Lease, Landlord may relocate Tenant in the Building or terminate this Lease.

16. MISCELLANEOUS

16.1 Landlord shall have no personal liability under this Lease. Tenant shall look solely to Landlord's equity in the Premises for satisfaction of Tenant's remedies against Landlord. Any holder(s) of any fee mortgage shall have no obligations whatsoever under this Lease. This Lease shall at all times be subordinate to any fee mortgage encumbering the Property. If the holder of any fee mortgage shall succeed to Landlord's interest in this Lease, Tenant shall, upon request, attorn to such holder in writing. In the event of any transfer of Landlord's interests, Landlord shall be released and relieved from all liability and responsibility thereafter accruing to Tenant and Landlord's successor shall be liable and responsible to Tenant with respect to all obligations of Landlord under this Lease accruing from and after the date of such transfer.

16.2 Tenant shall, on the last day of the Term or upon any termination of this Lease, surrender and deliver up the Premises to Landlord "broom clean" and in good condition and repair, subject to ordinary wear and tear, with all equipment and tenant improvements removed if Landlord so requests. All personal property and other belongings that are left upon the Premises at the time of such surrender shall be deemed to have been abandoned. The cost to Landlord of removal, sale and/or storage of such property shall be paid to Landlord by Tenant.

16.3 If Tenant does not immediately surrender the Premises to Landlord at the end of the Term, then Tenant shall pay to Landlord double the amount of the Rent payable by Tenant for the last month of the Term for each month or portion thereof that Tenant holds over, plus all damages that Landlord may suffer on account of Tenant's failure to surrender possession to Landlord, and shall indemnify and save Landlord harmless from and against all claims made by any succeeding tenant of the Premises or broker procuring such tenant, related to delay in delivering possession to such succeeding tenant, so far as such delay is occasioned by failure of Tenant so to surrender the Premises. No receipt of money by Landlord from Tenant after termination of this Lease or the service of notice of suit or judgment for possession shall reinstate or extend the Term or affect any such notice, demand, suit or judgment. No act or thing done by Landlord or its agents, including acceptance of keys to the Premises, during the Term shall be deemed an acceptance of a surrender of the Premises, and no agreement to accept a surrender of the Premises shall be valid unless it be made in writing and subscribed by a duly authorized officer or agent of Landlord.

16.4 At any time and from time to time during the Term, within ten (10) days after request by Landlord, Tenant will execute, acknowledge, and deliver to Landlord and its designees, a certificate which states (a) that this Lease is unmodified and in full force and effect, or if there have been modifications, that this Lease is in full force and effect as modified, and identifying the modification agreements; (b) the date to which the Rent has been paid; (c) the nature and extent of any existing default by either party as to which a notice has been given to the other party; (d) whether or not there are any setoffs, defenses, or counterclaims against enforcement of the obligations to be performed under this Lease existing in favor of Tenant; and (e) other matters which Landlord may reasonably request.

16.5 If a claim for brokerage or similar fees in connection with this transaction is made by any other broker, agent, salesman, or finder other than Brokers claiming to have dealt through or on behalf of one of the parties to this Lease, then such party shall indemnify, defend, and hold harmless the other party from all liabilities, damages, claims, costs, fees, and expenses (including reasonable attorneys' fees) with respect to such claim for brokerage. The provisions of this Section shall survive the expiration or termination of this Lease.

16.6 Each Notice shall be deemed to have been given (a) when in writing; (b) when sent by personal delivery, facsimile, Federal Express or other widely recognized overnight delivery service, or registered or certified mail; (c) upon receipt or refusal of receipt by the person to whom it is addressed; and (d) when addressed to each applicable person at the applicable addresses set forth on the first page of this Lease, or to such other person or address as a party shall in the future designate by giving notice to the other.

16.7 Each party represents to the other that it has full legal right, power, and authority to enter into, execute, and perform this Lease. All the rights and remedies of Landlord under this Lease or pursuant to present or future law shall be deemed to be separate, distinct, and cumulative. No one or more of them, whether exercised or not, nor any mention of or reference to any one or more of them in this Lease, shall be deemed to be in exclusion of, or a waiver of, any of the others, or of any of the rights or remedies which Landlord may have under this Lease, at law, and/or in equity. Landlord shall have, to the fullest extent permitted by law, the right to enforce any rights or remedies separately and to pursue any lawful action or proceedings to exercise or enforce any right or remedy without thereby waiving or being barred or estopped from exercising and enforcing any other rights and remedies by appropriate action or proceedings. No waiver by Landlord of any breach by Tenant of any term or condition of this Lease, and no failure by Landlord to exercise any right or remedy in respect of any such breach, shall constitute a waiver or relinquishment for the future, or bar any right or remedy of Landlord in respect of, any other breach of such term or condition or any breach of any other term or condition of this Lease. No payment by Tenant or receipt of payment by Landlord of an amount less than the full amount then due Landlord under this Lease shall be construed as anything other than a partial payment of such sum then due and owing. No endorsement or statement on any check or letter or any form of payment or accompanying document shall be deemed to be an accord and satisfaction or other form of settlement; Landlord may accept any such payment without prejudice to its rights to recover the balance of sums due and owing under this Lease or to pursue any other remedy permitted under this Lease.

16.8 Whenever under this Lease Landlord's consent or approval is expressly or impliedly required, it may be arbitrarily withheld. If Tenant requests

Landlord's consent or approval, and if in connection with such request Landlord seeks the advice of its attorneys, architect and/or other adviser or expert, then Tenant shall pay such persons' costs and fees related to such request and the preparation of related documents, which costs and fees shall be limited to $750 per request for matters in the normal course of Tenant's business. Such limitation shall not apply for extraordinary matters such as improvements or remodeling, or any work of any nature that might affect the Building's structural integrity or building systems.

16.9 All obligations of Tenant that are or may be intended by their nature to be performed and/or complied with after the expiration or earlier termination of this Lease shall survive such expiration or termination. Express provisions in this Lease that require or permit survival in specific instances, or as to specific obligations, shall not be deemed a limitation upon the generality of this survival clause. Every provision of this Lease shall be valid and be enforced to the fullest extent permitted by law. If any provision of this Lease, or the application of such provision to any person or circumstance, shall be determined by appropriate judicial authority to be illegal, invalid, or unenforceable to any extent, such provision shall, only to such extent, be deemed stricken from this Lease as if never included. The remainder of this Lease, and the application of such provision to persons or circumstances other than those as to which such provision is held illegal, invalid, or unenforceable, shall not be affected. In this Lease, "attorneys' fees means without limitation, accountants' and attorneys' fees, including fees for the services of paralegals and similar persons, consultant fees, investigation and laboratory fees, court costs, and litigation expenses at the trial and all appellate levels, and through collection.

16.10 The captions and headings contained in this Lease are for convenience and reference only, shall not be deemed to be a part of this Lease or construed as limiting, amplifying, or modifying in any manner the provisions of this Lease, and shall not otherwise affect the interpretation of this Lease. All references to Exhibits or Sections are to Exhibits or Sections of this Lease. Whenever the context of any provision of this Lease so requires, pronouns of any gender shall include the other genders, words in the singular shall include the plural, and words in the plural shall include the singular. This Lease may be executed and delivered in two or more counterparts, each of which shall be deemed to be an original and all of which, taken together, shall be deemed to be one instrument. The parties shall take all such actions and execute all such documents as may be necessary to carry out the purposes of this Lease, whether or not specifically provided for in this Lease. Time is of the essence as to all material terms of this Lease. This Lease shall be construed and governed in accordance with the laws of the State of California without application of conflict of law principles. All of the parties to this Lease have participated fully in its negotiation and preparation. Accordingly, this Lease shall not be more strictly construed against any one of the parties. Landlord shall not be deemed, in any way or for any purpose, to have become, by the execution of this Lease or any of the provisions of this Lease, or any action taken under this Lease, a partner of Tenant, in Tenant's business or otherwise, or a member of any joint enterprise or venture with Tenant.

16.11 This Lease contains the sole and entire agreement, and supersedes all other prior written or oral agreements, between the parties with respect to the subject matter of this Lease. This Lease may be changed, amended, or modified only by an agreement in writing signed by the party against whom such change, amendment, or modification is sought to be enforced. The terms and conditions of this Lease shall bind the parties and their respective successors and assigns, and shall inure to the benefit of the parties and their respective permitted successors and assigns. Any

waiver of rights by either party shall be deemed not only to be a waiver of such rights by such party but also a waiver of such rights for and on behalf of such party's successors and assigns.

16.12 IT IS MUTUALLY AGREED BY AND BETWEEN LANDLORD AND TENANT THAT THEY SHALL AND THEY HEREBY DO WAIVE TRIAL BY JURY IN ANY ACTION, PROCEEDING, OR COUNTERCLAIM BROUGHT BY EITHER LANDLORD OR TENANT AGAINST THE OTHER ON ANY MATTERS ARISING OUT OF OR IN ANY WAY CONNECTED WITH THIS LEASE, THE RELATIONSHIP OF LANDLORD AND TENANT, AND/OR TENANT'S USE OF OR OCCUPANCY OF THE PREMISES. TENANT FURTHER AGREES THAT IT SHALL NOT INTERPOSE ANY COUNTERCLAIM OR COUNTERCLAIMS (EXCEPT COMPULSORY COUNTERCLAIMS) IN ANY SUMMARY PROCEEDING OR IN ANY ACTION BASED UPON NONPAYMENT OF RENT OR ANY OTHER PAYMENT REQUIRED BY TENANT UNDER THIS LEASE.

The parties have executed this Lease on the date set forth in the first paragraph.

WITNESSES:

_____

_____

_____

Andy Irie, CAO

LANDLORD:

_____,

By: _____

Its: _____

TENANT:

_____,

By: Al Ballesteros

Its: Chief Executive Officer

By: _____

Its: _____

JWCH INSTITUTE, INC.
BUSINESS ASSOCIATE AGREEMENT

THIS CONTRACT is entered into this 1st day of February, 2014 by and _____, hereinafter known as "ASSOCIATE" and JWCH Institute, Inc., hereinafter known as "JWCH."

TERM: This contract shall be from February 1, 2014 to February 1, 2015 and shall automatically renew at the end of the term for another year. However, if either party elects to end the relationship, thirty-day notice shall be give to the other party. The party receiving the notice of termination shall respond in turn with written correspondence acknowledging the termination.

WHEREAS JWCH will make available and/or transfer to ASSOCIATE confidential, personally identifiable health information.

WHEREAS such information may be used or disclosed only in accordance with the privacy regulations [CFR §§ 164.502 (e); 164.504 (e)] issued pursuant to the Health Insurance Portability and accountability Act [42 USC §§ 1320-1320d-8] and the terms of this agreement:

NOW THEREFORE, the parties agree as follows:

1. *Protected Health Information* ("PHI") means individually identifiable information relating to the past, present of future physical or mental health or condition of an individual, provisions of health care to an individual, or the past, present or future payment for healthcare provided to an individual, as more fully defined in 45CFR § 164.501, and any amendments thereof, received from or on behalf of JWCH.

2. ASSOCIATE agrees that it shall not receive, create, use or disclose PHI except as follows:

    a. To conduct comprehensive assessments, deve1op and implement case management plans and develop and implement treatment plans for clients.

    b. If necessary for the proper management and administration of ASSOCIATE or to carry out legal responsibilities of ASSOCIATE. PHI may only be disclosed to another person/entity for such purposes if:

        i. Disclosure is required bylaw; or
        ii. Where ASSOCIATE obtains reasonable assurance from the entity to which disclosure is made that the PHI released will be held confidential.
        iii. Entity agrees to notify ASSOCIATE of any breaches of confidentiality.

    c. To permit ASSOCIATE to provide data aggregation services relating to the health care operations of JWCH.

3. ASSOCIATE and JWCH agree that neither will request, use or release more than the minimum amount of PHI necessary to accomplish the purpose of the use, disclosure or request.

4. ASSOCIATE will establish and maintain appropriate safeguards to prevent any unauthorized use or disclosure of PHI.

5. ASSOCIATE agrees that it shall immediately report to JWCH any unauthorized uses/disclosures of which it becomes aware, and shall take all reasonable steps to mitigate the potentially harmful effects of such breach. ASSOCIATE hereby indemnifies JWCH and agrees to hold JWCH harmless from and against any and all losses, expenses, damage or injury that JWCH may sustain as a result or, or arising out of, ASSOCIATE or its agent's or subcontractor's unauthorized use or disclosure of PHI.

6. ASSOCIATE shall ensure that all of its subcontractors and agents are bound by the same restrictions and obligations contained herein whenever PHI is made accessible to such subcontractors or agents, and shall give prior notice to JWCH of any subcontractors or agents who are to be given access to PHI.

7. ASSOCIATE shall make all PHI and related information in its possession available as follows:

    a. To the individual or his/her personal representative or to JWCH to the extent necessary to permit JWCH to fulfill any obligation to allow access for inspection and copying in accordance with the provision of 45CFR § 164.524.

    b. To the individual or his/her personal representative or to JWCH to the extent necessary to permit JWCH to fulfill any obligation to account for disclosures of PHI in accordance with 45CFR § 164.528.

8. ASSOCIATE shall make PHI available to JWCH to fulfill its obligation to amend PHI and related information in accordance with 45 CFR § 164.526, and shall, as directed by JWCH, incorporate any amendments or related statements into the information held by ASSOCIATE and any subcontractors or agents.

9. ASSOCIATE agrees to make its internal practices, books and record relating to the use of disclosure of information received from or on behalf of JWCH available to the US Secretary of Health and Human Services or the Secretary's designee for purposes of determining compliance with the privacy regulations and any amendments thereof.

10. Upon termination of the contracts ASSOCIATE agrees at the option of JWCH to return or destroy all PHI created or received from or on behalf of JWCH. ASSOCIATE agrees that it will not retain any copies of PHI except as required by law. If PHI is destroyed, ASSOCIATE agrees to provide JWCH with appropriate documentation or certification evidencing such destruction. If return or destruction of all PHI and all copies of PHI is not feasible, ASSOCIATE agrees t6 extend the protection of this Contract to such information for as long as it is maintained. Termination of this Contract shall not affect any of its provisions that, by wording or nature, are intended to remain effective and to continue in operation.

11. The PHI and any related information created or received from or on behalf of JWCH is and shall remain the property of JWCH. ASSOCIATE agrees that it acquires no title in or rights to the information, including any identified information.

12. Any non-compliance by ASSOCIATE with the terms of this Contract or the privacy

regulations shall be a breach of this Contract, if ASSOCIATE knew of the breach and failed to take immediate or reasonable steps to cure the non-compliance. ASSOCIATE agrees that JWCH has the right to immediately terminate this Contract and seek relief, including the right to contract for replacement service through another entity at the same cost, with ASSOCIATE responsible for paying any difference in cost, if JWCH determines that ASSOCIATE has violated a material term of the Contract.

13. Notwithstanding any rights or remedies under this Contract or provided by law, JWCH retains all rights to seek injunctive relief to prevent or stop the unauthorized use or disclosure of PHI by ASSOCIATE, any of its subcontractors or agents, or any third party who has received PHI from ASSOCIATE.

14. The Contract shall be binding on the parties and their successors but neither party may assign the contract without the prior written consent of the other, which consent shall not be unreasonably withheld.

15. Any notice to the other party pursuant to this. Contract shall be deemed provided if sent by first class United States mail.

JWCH Institute, Inc.

By Al Ballesteros
Chief Executive Officer
JWCH Institute, Inc.

St. Mary Medical Center/Dignity Health

Thomas Salerno, Chief Executive Officer
St. Mary Medical Center/Dignity Health

JWCH INSTITUTE, INC. Health & Medical Services

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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: ☐ Marisa Samano ☐ Melinda Garbutt ☐ 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)	☐	☐

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IMPORTANT, Pls Complete

(Follow-up Appts After Discharge)

Specialty	Date	Time	RM #	Contact #

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Click here to view FULL follow-up appt record

Form Completed By: _____ (Signature)

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RECUPERATIVE CARE PROGRAM
Provider Referral Form

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

Completed by MD / PA / NP only

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 (323) 263-8348. Please feel free to call us with any questions. We can be reached at (323) 263-8840.

Patient's Name: _____ Patient's MR#: _____

DOB: _____ SSN: _____

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

_____

_____

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

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 or ____ mos

_____ (Signature of Referring Provider) | _____ Provider PRINTED Name | _____ Contact Number | _____ Date

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FOR INTERNAL USE ONLY **FOR INTERNAL USE ONLY**

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

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

Reviewed by: _____ Provider Signature _____

JWCH INSTITUTE, INC. Health & Medical Services

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Completed by MD / PA / NP only

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 (323) 263-8348. Please feel free to call us with any questions. We can be reached at (323) 263-8840.

Patient's Name: _____ Patient's MR#: _____

DOB: _____ SSN: _____

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

_____

_____

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

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)

S3: C-11, click here to see communicable dz disclosure

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 or ____ mos

(Signature of Referring Provider)	Provider PRINTED Name	Contact Number	Date

FOR INTERNAL USE ONLY **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

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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 S3: C-11 Click here to return to Standards Page
☐	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 213.572.0321 . Please be sure to include this checklist.

JWCH INSTITUTE, INC.
Health & Medical Services

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

MEDICATION RECONCILIATION

(Please List Only Medications Given At Discharge)

IMPORTANT!!

Medication and Strength	Route	Freq	Stop Date (if IV)
	☐ PO ☐ IM | SC | IV ☐ Topical		
	☐ PO ☐ IM | SC | IV ☐ Topical		
	☐ PO ☐ IM | SC | IV ☐ Topical		
	☐ PO ☐ IM | SC | IV ☐ Topical		
	☐ PO ☐ IM | SC | IV ☐ Topical		
	☐ PO ☐ IM | SC | IV ☐ Topical		
	☐ PO ☐ IM | SC | IV ☐ Topical		
	☐ PO ☐ IM | SC | IV ☐ Topical		
	☐ PO ☐ IM | SC | IV ☐ Topical		
	☐ PO ☐ IM | SC | IV ☐ Topical		
	☐ PO ☐ IM | SC | IV ☐ Topical		
	☐ PO ☐ IM | SC | IV ☐ Topical		
	☐ PO ☐ IM | SC | IV ☐ Topical		

Patient Name: ______________________________
Please Print

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

Patient Name: _____
Please Print

Referring Provider **ONLY:** _____ _____
Signature Date

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

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Recuperative Care History and Physical Assessment Form

Patients Name (LAST, First): _____
Date of Birth (dd/mm/yy): _____
Today's Date: _____
Provider Name: _____
Hospital/Clinic of Origin: _____

Time Seen: _____ Medical Record#: _____

Reason For Admission to Recuperative Care:

History of Present Illness:

Patient is reminded of the follow-up appt with referring hospital or other community provider:

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1)
2)
3)

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Past Medical History	**Current Medications & Dose:**
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Vaccinations:	**Family Hx:**

	Disease	Relative/comments	
		Mom	
Past Surgical History:		Dad	
		Siblings	

	Social Hx:
Past Psychiatric History:	
	Habits

		Y	N	Comments
	Tobacco:			
	Alcohol:			
	Illicit Drug:			

Physical Examination

Vital Signs:	HT:		WT:		BP:		Pulse:	/min	Resp:	/min
	Allergies				Temp:	°F	Pain Level	Location:		
					LMP:	n/a		/10	RBS:	

Head				**Abnormal Findings/Comments**
	No deformities			
	No evidence of recent trauma			
Skin: Color :				
	No rashes or eruptions			
	No ulcerations			
	See Extremities			
Lymph Nodes				
	Cervical, axillary, supraclavicular and			
	Inguinal nodes are not palpable			
Eyes				
	Vision grossly intact			
	Pupils: R	mm	L mm	
		PERRLA		
	EOM Intact			
	Fundi:			
		Disc not elevated, margins distinct		
		Vessels without narrowing or AV nicking		
		No capillary aneurysms		
		No hemorrhages or exudates		
Ears				
	Symmetrical – no deformities			
	Canals clear			
	Tympanic membranes intact			
	Hearing grossly intact			
Nose				
	No marked obstruction to airway			
	Mucosa pink & moist, no pus in meati			
	Septum intact			
Oral Cavity				
	Mucosa pink & moist, no sores or leukoplakia			
	No lymphoid hyperplasia			
	Hygiene good, teeth in good condition			
Neck				
	Supple			
	Thyroid without mass/enlargement			
	No venous distension			

Physical Examination Cont…	
Breast	**Abnormal Findings/Comments**
Symmetrical	
No Tenderness	
No masses or ulcerations	
No discharge from nipples	
Deferred	
Back	
No deformities of spine	
No CVA tenderness	
No muscle spasms	
Chest	
No deformities	
Lungs clear to percussion & ausc.	
Heart	
Normal rhythm and rate	
PMI: ICS at:	
No lifts, heaves, or thrills	
Normal S1S2	
No murmurs	
A2 equal P2	
JVD: cm	
S3, S4	
Abdomen	
Flat and soft	
No tenderness or rigidity	
No masses	
Normoactive bowel sounds	
No scars	
No hernias	
Extremities	
No clubbing or cynanosis	
No edema	
No deformities	
No open wounds	
Rectal	
No hemorrhoids	
Sphincter tone good	
Prostate symmetrical & normal consistency	
No masses or tenderness	
Stool brown & neg for occult blood	
Deferred	
Rectal exam not indicated because	
Recently done:	
Acute myocardial infarction	
Neutropenia	
Refused by patient	

Physical Examination Cont…	
Pelvic:	**Abnormal Findings/Comments**
☐ No lesions of vulva	
☐ No vaginal discharge	
☐ Vaginal wall well supported	
☐ Urethral meatus normal	
☐ No lesions of cervix	
☐ Fundus symmetrical, no enlarged, freely movable	
☐ No adnexal masses or tenderness	
☐ Deferred	
Pelvic exam not indicated because	
☐ Recently done:	
☐ Acute myocardial infarction	
☐ Neutropenia	
☐ Refused by patient	
Male genitalia	
☐ No penile lesions	
☐ Both testicles in scrotum	
☐ No masses or swellings ☐ Deferred	
Neurological	
☐ Language receptive and expressive	
☐ Memory intact, oriented x 3	
☐ Appropriate behavior	
☐ Normal intelligence	
Motor	
☐ No weakness, paralysis, tremor	
☐ No fibrillation, fasciculation, or atrophy	
☐ No disturbance of gait or stance	
Sensory	
☐ No numbness or tingling	
☐ Position and vibratory sense intact	
☐ Sensation grossly intact to pin-pink	

Laboratory Data	
TB Status	Chemistry
☐ Last PPD:	
☐ Result: ☐ **Neg** ☐ **Pos**	
☐ If positive, last CXR:	
Pertinent Radiologic Studies:	CBC:
Electrocardiogram: ☐ Done ☐ Not Done	Other:

Physical Examination Cont…	
Assessment & Plan	**Consults**

Problem 1		
1.		
2.		
3.		
4.		
5.		
6.		

Problem 2		
1.		
2.		
3.		
4.		
5.		
6.		

Problem 3		
1.		
2.		
3.		
4.		
5.		
6.		

Problem 4		
1.		
2.		
3.		
4.		
5.		
6.		

Problem 5		
1.		
2.		
3.		
4.		
5.		
6.		

Problem 6		
1.		
2.		
3.		
4.		
5.		
6.		

Physical Examination Cont…	
Assessment & Plan	**Consults**
Problem 7	
1.	
2.	
3.	
4.	
5.	
6.	

Problem 8	
1.	
2.	
3.	
4.	
5.	
6.	

Problem 9	
1.	
2.	
3.	
4.	
5.	
6.	

Recup Admission Orders

1) Admit to Recup Care
2) Hospital discharge instructions and f/u care discussed with pt
3) Medication reconciled and discussed with patient

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Pt expresses verbal understanding and is able AND willing to follow instructions:

☐ Yes ☐ No S3: C-13, click here to return to Standards pg

RTC 1 wk

PROVIDER SIGNATURE:

DATE:

INITIAL ORDERS:

☐ PPD ☐ Dtap ☐ CXR ☐ EKG

OTHER:

Wound Care: ☐ Wet to dry ☐ Dry dressing — Frequency:

Tx Area:

LAB

☐ Today ☐ Schedule:

☐ Initial (CMP, ALT, CBC, RPR) ☐ Lipid profile

☐ HbA1C ☐ PSA ☐ UA ☐ µ Al/Cr

Other Labs:

Ref hops ELOS: wks Recup ELOS: wks

Next MD/PA Appt:

☐ Dennis Bleakley, MD ☐ Lucien Alexandre, MD

☐ Thanh Chu, PA-C ☐ Other:

Patient Appointment Record

Patient Name: _____ CC: _____ Room Number: _____

Type of assistance needed with appts: ☐ Escort ☐ Buddy

Appt Date	Time	Institution & Address	Dept/ Specialty	RM#	Contact #	Appt Kept?		
						Y	N	Rescheduled Date