4.1 ADA Accessibility

Policy: Interfaith House is an ADA accessible, 24-hour/day facility providing services to adults who are homeless and who need time and a safe, clean and supportive place to complete their recovery from an acute medical condition. Interfaith House services are provided at no cost to our residents.

_____ _____

Jennifer Nelson-Seals Date

5+1 Cr 4

Program Team – Reasonable Accommodation for Persons with Disabilities

Policy

Interfaith House is committed to serving ill and injured homeless adults in need of medical recovery. While we attempt to provide a comprehensive system of services within our programs, there may be individuals with particular physical disabilities that require services beyond our capabilities to improve their stay here. For these individuals, local agencies will be contacted to provide this support.

Procedure

1. Once a resident is identified as having a disability requiring further support than our staff is able to provide, the team member will make the referral to the appropriate agency within the Continuum of Care or within Chicago's mainstream system of services.
2. If possible, a linkage will be signed with the agency receiving our referral to facilitate continuity of care for this resident and others.
3. The resident will be supported through transportation and effective communication with the agency to ensure the delivery of services.

_____ _____

Michael Cook, Executive Director Date

St 1 Gr 5

Resident Valuables Form

Resident's Name: _____ Room #: _____

Date of Intake: _____/_____/_____

I acknowledge that Interfaith House is not responsible for items that you keep in your possession, including your locker. Interfaith House provides "banking service" for residents' valuables. Valuables are defined as cash, checks, money orders, important documents, credit cards, and jewelry. Valuables may be deposited or withdrawn during banking hours. Banking hours at Interfaith House are Monday, Wednesday, and Friday, from 2:30pm to 3:00pm.

Please be advised that after you have been discharged from Interfaith House you have 6 months to pick up any valuables deposited with the Interfaith House Resident Bank. After 6 months, Interfaith House is authorized to dispose of any of my property.

Resident Signature: _____ Date: _____/_____/_____

Staff Signature: _____ Date: _____/_____/_____

Revised March 2014

St 1 Cr 5
St 2 Cr 3

Interfaith House
Health Services – Medication Policy and Procedure

Policy

All program staff are responsible for the monitoring of resident medications, staff are trained as a part of their orientation to Interfaith House and as policies and procedures change or are updated they are informed and retrained. All residents are responsible for obtaining their own medications prior to their arrival and throughout their stay. Interfaith House does not administer medications but only assumes responsibility for their safekeeping, and monitors their distribution. Medications are stored and locked in the medication room and the keys are kept at Central Desk..Upon intake all medications are logged, the number of pills and the frequency is also logged on the individual's medication sheet; controlled medications are also counted and logged on a separate sheet and counted each time a resident takes one. All resident medications are stored in the respective resident's assigned drawer or refrigerator according to manufacturer's recommendations. Residents are not permitted to share their prescribed medications with other residents.

Procedure

1. Each resident is required to arrive with a 30-day supply of medication. Obtaining medication is the responsibility of the resident and his/her health-care provider. Refills or new medications needed during a resident's stay are also the responsibility of the resident. Each resident is responsible for meeting with the appropriate medical care professional in order to refill his/her medications.
2. Each resident's medications are counted and documented on the *Medication List* upon arrival. A *Medication List* is placed in each resident's file and medications are placed into each resident's medication drawer in the medication room. Medication forms are to be filled out according to the *Medication Box Procedure* sheet.
3. Residents who require medication must report to the medication room during the scheduled daily medication times. If a resident needs to take PRN medication not during one of the scheduled medication times, an RCA or other staff member will assist the resident. Residents are responsible for taking medications as prescribed by their physicians. Any adverse side effects, interactions or allergic

reactions are discussed with the medical staff. The Staff is responsible for observing and recording all medications taken by residents.

4. All medications must be put away after use and never left unattended in the medication room. The medication room should be locked whenever it is unattended.

5. Please refer to the current *Controlled Medications* sheet for a list of all controlled medications. In the event that there is a discrepancy in the count of a controlled medication, a senior staff member will be notified.

6. Discontinued or expired medications will be removed by Staff or an MCP to be stored and picked-up by stericycle for the safe disposal of this medication. In addition, discontinued medication will be recorded as such in the resident's chart.

_____ _____

Jennifer Nelson-Seals, Executive Director

Date:

Greater Chicago Food Depository
Providing Food For Hungry People

4100 W. Ann Lurie Place
Chicago, IL 60632

CERTIFICATE OF MEMBERSHIP RECEIPT AND INSPECTION

THE UNDERSIGNED AGENT OF:

Inter Faith House

Hereby warrants that as a representative of said agency he/she will receive assorted foods from the
Greater Chicago Food Depository

It is further agreed between the GREATER CHICAGO FOOD DEPOSITORY and said CHARITABLE AGENCY that:

1. The food is accepted "as is."
2. Greater Chicago Food Depository and the original donor expressly disclaim and implied warranties of merchantability of fitness for a particular use. There have been no expressed warranties in the relation to this gift of food.
3. It is the responsibility of the agency to inspect all goods received through the FOOD DEPOSITORY and withhold from distributing and food item that might be spoiled or inedible.
4. Said CHARITABLE AGENCY releases both the original donor and Greater Chicago Food Depository from any liability resulting from the condition of donated food, and further agrees to indemnify and hold Greater Chicago Food Depository and the original donor free and harmless against all and any liabilities, damages, losses, claims whatsoever arising out of attributed to any action of said CHARITABLE AGENCY in connection with it's storage, handling, and use of donated food.
5. It is the responsibility of the CHARITABLE AGENCY to keep and maintain necessary records which show that goods received through the FOOD DEPOSITORY have been given to the needy in the Cook County Area with out regard to race, religion, gender or age.
6. Said CHARITABLE AGENCY will not sell or offer said for sale. Said CHARITABLE AGENCY will not request contributions or membership or membership fees from recipients, directly or indirectly for said food. Said CHARITABLE AGENCY agrees to serve and/or distribute all goods received without monetary charge or by any medium exchange.
7. The CHARITABLE AGENCY will contribute to the support of the FOOD DEPOSITORY on the basis of the established shared maintenance system.\
8. If violations of the agreement above occur or non-compliance of Membership Eligibility Requirments, said CHARITABLE AGENCY will be suspended or terminated from membership of the Greater Chicago Food Depository.

ACKNOWLEDGED THIS 11 OF November IN THE YEAR OF 2014

(Signature of Authorized of Agent) (Title)

3456 W. Franklin Blvd (Agency Site Address) Chicago (City) IL, 60624

(Executive Director: Greater Chicago Food Depository)

Stler7

Food Services – Food Storage

Policy

The food storage facilities consist of Store Rooms A and B, freezer, refrigerator and spice rack. To ensure quality, all stored food is rotated and inventoried regularly. Maintenance of the storage space is the responsibility of the Food Service Manager and the designated dietary service workers.

Procedure

1. When food is delivered the previously received food is rotated so that the freshest stock is available for use.
2. Weekly inventory is taken of all food to see what is needed.
3. The food storage areas are regularly swept, mopped, and cleaned.

_____ _____

Jennifer Nelson-Seals Date

1.9

TO: James Nolan
Please file in
Melissa's folder

Certified Professional Food Manager

designation has been conferred upon

MELISSA A LAMMONS

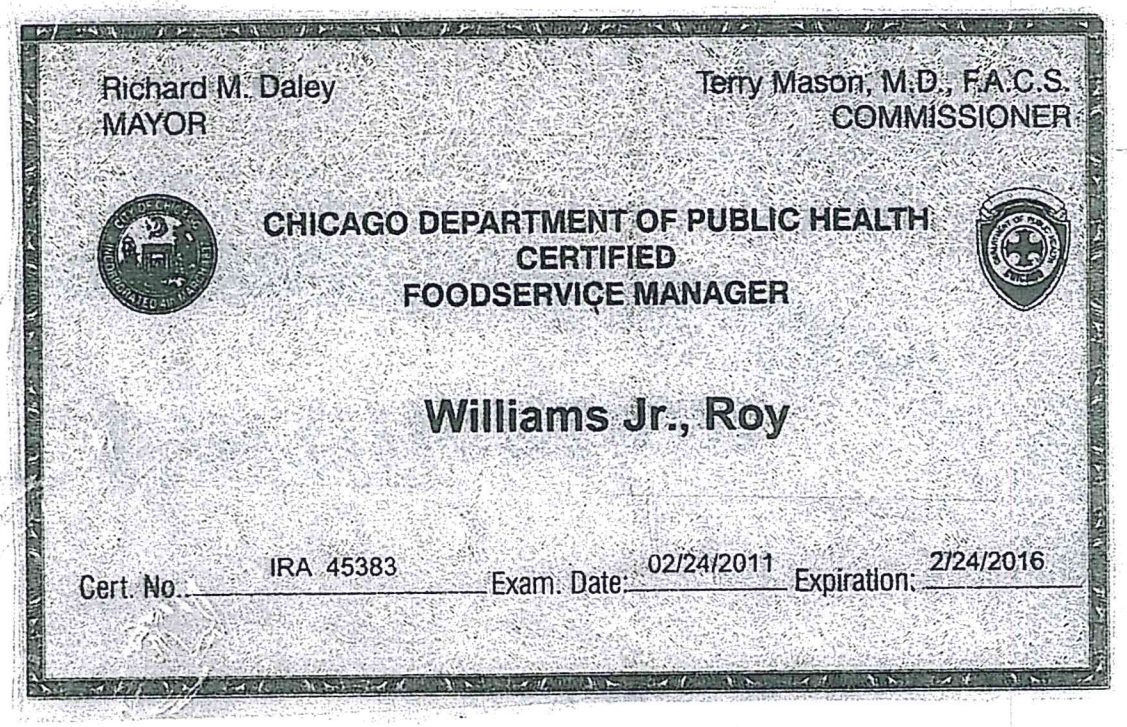
who has met all the professional requirements for certification in food service safety and sanitation.

Exam 1504 Recognized By Conference For Food Protection

Ryan McMillion, Client Services Manager

Certificate No: 1779689
Exam Date: 09/17/13
Test Code: 621804150
Certificate expires no later than: 09/17/18

ANSI



Richard M. Daley
MAYOR

Terry Mason, M.D., F.A.C.S.
COMMISSIONER

CHICAGO DEPARTMENT OF PUBLIC HEALTH
CERTIFIED
FOODSERVICE MANAGER

Williams Jr., Roy

Cert. No.: IRA 45383 Exam. Date: 02/24/2011 Expiration: 2/24/2016

ServSafe®

EXAM FORM NO. 4675

CERTIFICATE NO. 8549832

ServSafe® Certification

TO DELORA L SCOTT

for successfully completing the standards set forth for the ServSafe® Food Protection Manager Certification Examination, which is accredited by the American National Standards Institute (ANSI)–Conference for Food Protection (CFP).

11/02/2011

DATE OF EXAMINATION

11/02/2016

DATE OF EXPIRATION

Local laws apply. Check with your local regulatory agency for recertification requirements.

ANSI ACCREDITED PROGRAM American National Standards Institute and the Conference for Food Protection®

#0655

Paul Hineman
Executive Director, National Restaurant Association Solutions

NATIONAL RESTAURANT ASSOCIATION®

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1 of 6

4.0. Dietary:

Meals

Policy: Interfaith House provides each resident three meals a day and a snack each evening. Residents need to sign-in for each meal before receiving their tray. Residents needing assistance with their trays will be served first. A salad bar is provided on weekdays; only four people should be at the salad bar at one time. If there is enough food for seconds, a call will be made by the Dietary staff. If a resident is signed out for an appointment, a meal plate will be saved for them, a lunch plate will be saved for those that have signed out in the morning. A dinner plate will be saved for those that have signed out in the afternoon. Residents that will be out of the building on appointment or employment all day should go to Central Desk or see their case manager to request a bag lunch. Meals will not be held for residents signed out on pass. All food must be eaten in the dining area.

_____ _____

Jennifer Nelson-Seals Date

St 1 Cr 7

INTERFAITH HOUSE

NUTRITION SERVICES

Dietary Need Request

Date of Intake: _____

Resident Name: _____ Room #_____

Dietary needs (check all that apply; if no special needs, check general diet only):

_____ General Diet

_____ Diabetic

_____ Low cholesterol

_____ Low Salt/Sodium

_____ Renal/Dialysis

_____ Lactose Intolerant

_____ Liquid Diet

_____ Calorie: _____

_____ Vegetarian / Vegan

_____ Other_____

Food Allergies: _____

Religious Food Restrictions: _____

_____ _____

Resident Signature Date

Please put in the Dietary Services Manager mailbox.

Revised March 2014

YAKIMA NEIGHBORHOOD HEALTH SERVICES
After Hours On Call Provider

Rotation:
The call week is Thursday – Thursday. The on call bag should be dropped off/picked up by 3:00 pm each Thursday in the yellow nurses' station. If a provider is not able to drop off/pick up the bag by 3:00 pm, they must notify the provider currently on call or scheduled to be on call to make other arrangements.

Hours of Call:
The on call pager/after-hours phone number is available at all times the clinic is closed. This includes:

- Weekdays 6:00 pm - 8:00 am
- Holidays
- Saturdays 6:00 pm to Monday 8:00 am
  or
- All day Saturday if there is no walk-in provider to Monday 8:00 am
- Any time a provider is unavailable in the clinic, the on call provider should be notified and available for telephone call.

Schedules:
The on call provider schedule is typically prepared three months in advance. If the scheduled on call provider wants to change his/her designated call rotation, he/she should arrange with another provider and notify the MA Supervisor at least one month before the requested call duty to minimize rescheduling of patients.

Call Bag:
The After Hours on Call bag should be checked by oncoming provider for the following:

- Pager
- Cell phone/charger
- Extra AAA battery
- Hospitalists contact numbers
- Provider/interpreter home phone numbers
- Supervisor list
- Out Patient Call Log
- Card with interpreter number and Spanish phrase for call back
- YNHS Dental Pager number

Miscellaneous:
The after-hours number is a service for YNHS patients who have medical questions or concerns that can't wait to be addressed during business hours to use when the clinic is closed.

Each call received should be returned within 30 minutes and documented in the patient's electronic record utilizing the Standard Communication template categorized as "After Hours Call". If direct entry into the electronic record is not available, the designated call sheet may be used. Completed call sheets should be routed for disposition the following business day.

As a general rule, on call providers do not call in prescriptions for patients.

Excerpted from Care Guidelines

Yakima Neighborhood Health Services
12 South 8th St, PO Box 2605
Yakima WA 98907-2605
Phone (509) 454-4143 Fax (509) 454-3651
www.ynhs.org

Date: _____

RESPITE WELCOME

To YNHS/Neighborhood Connections Respite shelter program

IN CASE OF AN EMERGENCY CALL **911**

Your address location is **207 south 4th Street #___** (MAIL DOES NOT STOP AT THIS ADDRESS, DO NOT USE AS A MAILING ADDRESS).

If you are a patient of YNHS to make or confirm an appointment call:

Yakima Neighborhood Health Services	**509-454-4143**
Neighborhood Connections	**509-834-2098**

If you have a medical problem and the clinic is closed:
A medical condition that can't wait Dial **509-577-5172**

Maintence problem: Michael **509-426-0699**

Transportation through People for People: **509-248-6793**
(*Have your medical coupon available*)

Yakima Neighborhood Health Services Outreach Staff:

Eliel Cruz-Brito	509-949-1937
Ramiro Gomez	509-949-9686
Outreach Nurse	509-949-9685

Annette R. 509-949-9122 Outreach Coordinator/Supervisor

Accredited by the Joint Commission on Accreditation of Healthcare Organizations

Interfaith House Provider Contact List
2014

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
Morning (9:00 – 12:00)	CABANILLA	T. KAWAI	S. CARREON (1pm-4)	LOVAASEN	K.McDONOUGH

PROVIDER	OFFICE	PAGER	CELL	EMAIL
C Cabanilla MD	PCC Melrose Park (708) 406-3040	(630) 255-3151	(573) 823-4677	cbernardo@pccwellness.org
Tamayo Kawai MD	PCC Melrose Park (708)-406-3040	(630)-255-3651	(347)-860-4724	tkawai@pccwellness.org
Sarah Carreon MD	PCC Lake (708) 383-0113	(708) 947-0221	(773) 716-5001	scarreon@pccwellness.org
Emily Lovaasen MD	PCC Austin (773) 378-3347	630-255-3655	630-947-5022	elovaasen@pccwellness.org
Katie McDonough MD	PCC Austin (773) 378-0455	(630) 255-4011	(847) 219-3441	kmcdonough@pccwellness.org
Beth Dowell DO	PCC North (708) 406-3040	(708) 255-1597	(708) 209-8698	eadowell@gmail.com

Dr. Paul Pagee (630) 255-6814

Program Team – Emergency Discharge

Policy

Interfaith House will not discharge any resident unless an appropriate placement has been found for them. The decision to discharge and the subsequent placement are the responsibility of both the resident and the case manager. However, if a resident violates house rules by engaging in violent behavior, either verbal or physical, a senior staff member will proceed with an emergency discharge procedure. The first responsibility of the staff on duty is to protect other residents, the staff, and the facility from violent harm. The second responsibility is to isolate the violent resident and discharge him or her quickly.

Procedure

1. In response to a violent incident, immediately notify the police by calling 911.
2. As soon as it is possible and safe, alert the senior staff on call. Tell them we have an emergency situation.
3. Isolate the resident from the rest of the community in whatever way possible, with the assistance of other staff or, if necessary, other residents, especially members of the supportive living program.
4. As the resident is leaving Interfaith House, follow standard discharge procedure as much as possible, making a special effort to return medications to the departing resident.

_____ _____

Michael Cook, Executive Director Date

YAKIMA NEIGHBORHOOD HEALTH SERVICES
URGENT CARE PROTOCOL

It is the procedure of Yakima Neighborhood Health Services to be prepared to deliver basic emergency services to our patients should a medical emergency occur on site.

PROCESS:
In the event of a medical emergency, (i.e. respiratory arrest, cardiac arrest, anaphylaxis, loss of consciousness) "Code Blue", "Location" should be called by overhead page and tracker, as available. If it is known that there is a low number of medical providers, nurses and medical assistants (e.g., on Saturdays, at satellite locations, after 5:00 pm or before 8:30 am), staff member may have the option of calling, "Code Blue, + location, ALL RESPOND".

If an "ALL RESPOND" is activated, All YNHS staff members at the site should respond to the code. If any staff member at the scene is BLS trained he/she begins to assess Airway, Breathing and Circulation and starts BLS.

If an "ALL RESPOND" code is NOT activated, the following staff members should respond immediately:

First Responders:

All Medical Providers
All Medical Assistants
All Nurses
All Supervisors
Pharmacist
Medical Supply Clerk

Designated responding staff should obtain the urgent care supplies. Urgent care supplies may include an Urgent Care Kit, Oxygen tank and Oxygen Supply Bag, Defibrillator Unit, and Anaphylaxis Kit, as appropriate to the scope of services offered at that site. Urgent care supplies are maintained in the following sites and locations:

- 8th Street Site Medical
  - urgent care cart and oxygen in Pod 2 and
  - urgent care cart and oxygen in 2nd floor east hallway
- 8th Street Site Dental
  - urgent care kit in Operatory 2 cabinet
- Neighborhood Connections
  - urgent care cart and oxygen near employee North entrance
- Southeast Community Center
  - urgent care cart and oxygen in the Provider Room
- Sunnyside
  - urgent care cart and oxygen adjacent to the east nurse's station

Staff then proceed to the code location. Urgent Care Responsibilities have been designated for staff. The first medical provider on the scene is the code captain until a more qualified provider arrives

All Staff – Emergency Evacuation in the Case of Fire

Policy

In the event of fire or smoke, employees are responsible for their own safety and ensuring full evacuation of the building. Remember the R-A-C-E code:

R Rescue anyone in immediate danger from fire or smoke.

A Activate the nearest fire alarm pull station. The fire alarm will sound throughout the facility. The on-duty employee at the reception area will check the fire alarm panel for the location of the fire and then dial 911 to notify the Chicago Fire Department.

C Confine the fire by closing the door to the fire area, but do not lock the door.

E Extinguish the fire. All employees are trained in the proper selection and use of fire extinguishers.

Procedure

1. When the fire alarm sounds all occupants of the facility must leave the facility.
2. Occupants exit the building at the nearest exit on the ground floor.
3. The elevator will not be used during a fire evacuation.
4. In addition, the staff have the following responsibilities during evacuation.
    a. The on-duty senior staff will report to the reception area to direct the efforts of the employees to effect a prompt and orderly evaluation of the facility. The on-duty senior staff will meet the fire department at the front entrance of the facility. The senior staff informs the fire department of the location of the fire and the status of the evacuation. The senior staff must also have a copy of the floor plans of the facility with all utility locations well marked.
    b. One employee will be assigned to each ground floor exit to the facility. These employees will gather all occupants leaving by that exit and then escort them to the front of the building.
    c. Two employees will go to the second floor, two will go to the first floor, and one to the basement. These employees will ensure that all the occupants have left the building and also assist any occupants that may be having difficulties. These employees will report to the on-duty senior staff at the reception desk before leaving the facility. They will report on the condition of the area for which they are responsible.
    d. One employee will gather residence attendance information and the visitor sign-in register and will report to the front of the facility. This employee will then take attendance to ensure that the occupants are out of the facility and accounted for.
    e. Kitchen employees will ensure that all gas and electric appliances are turned off before reporting to the front of the facility.
    f. All non-assigned employees will report to the reception area for possible assignments before leaving the facility.
    g. No one will be allowed to reenter the facility unless under the direction of the fire department.

_____ _____

Michael Cook, Executive Director Date

St 1 Cr 7

14 Facilities Management

14.1 Fire Evacuation

Policy:
In the event of observance of fire or smoke, employees are responsible for evacuating the building and ensuring their own safety. If fire or smoke is noticed in a resident room, office, storage room, or a bathroom; please ensure no occupants are in the room and close the door. Notify Central Desk of the location of the smoke or fire.

Remember the R-A-C-E code.
R Rescue anyone in immediate danger from fire or smoke.
A Activate the nearest fire alarm pull station. The fire alarm will sound throughout the facility.
C Confine the fire by closing the door to the fire area, but do not lock the door.
E Extinguish the fire. All employees are trained in the proper selection and use of fire extinguishers.

Procedure:

1. When the fire alarm sounds all occupants must immediately evacuate the facility.
2. Occupants exit the building at the nearest exit on the ground floor. The main fire exits are at the northern and southern end of the building.
3. The elevator will not be used during a fire evacuation.
4. In addition, staff has the following responsibilities during evacuation:

    a. The on-duty employee at Central desk will check the fire alarm enunciator panel for the location of the fire and then dial 911 to notify the Chicago Fire Department.

    b. The on-duty senior staff member will direct the efforts of the employees to ensure a prompt and orderly evacuation of the facility.

    c. Any employees on the basement, first floor, and second floor will check rooms and bathrooms to ensure all residents have exited the building; and assist any occupants that may have difficulties.

    d. The on-duty senior staff will meet the fire department at the front entrance of the facility and inform the fire department of the location of the fire and the status of the evacuation. The senior staff member should also have a copy of the floor plans of the facility with all utility locations well marked.

    e. Kitchen employees will ensure that all gas and electric appliances are turned off before reporting to the front of the facility.

    f. No one will be allowed to reenter the facility unless under the direction of the fire department.

_____ _____
Jennifer Nelson-Seals Date

State of Illinois
Illinois Environmental Protection Agency

2.1

This Agency is authorized to require this information under the Illinois Environmental Protection Act, Ill. Rev. Stat., 1989, ch. 111 1/2, pars. 1001 et. seq. ("Act") Section 4 and Public Act 87-752, amending the Act effective January 1, 1992. Disclosure of this information is required. Failure to do so may result in a civil penalty according to Section 42(a) of the Act and a criminal penalty according to Section 44(a) of the Act. This form has been approved by the Forms Management Center.

Illinois Potentially Infectious Medical Waste Manifest

M 422 831

1. **HAULER** NAME AND ADDRESS: EMERGENCY TELEPHONE: 1-800-424-9300 Customer No. 21132
2. PHONE (219) 886 - 3628
3. PIMW HAULING PERMIT M9025
4. LICENSE PLATE 622RPT STATE IN

Stericycle, Inc.
1310 Michigan Street
Gary, IN 46402

Richard J Saager — 5/20/2014

5. NAME (PRINT/TYPE) SIGNATURE DATE

6. NUMBER OF CONTAINERS 4 7. TOTAL NET WEIGHT ____ (LBS) 17.2 (CU. FT.)
8. FEE DUE: LBS x $.03 = ____ 9. Acknowledgement of Fee (Signature)

I further declare that this facility has a process or procedures in place designed to prevent inclusion of mercury waste in these materials.

10. **GENERATOR** NAME AND ADDRESS:
JOSE MORALES
INTERFAITH HOUSE
5456 W FRANKLIN BLVD
CHICAGO, IL 60624-1305

11. PHONE (773) 533-6013

12. TYPE OF WASTE:
- ☐ UN2814, INFECTIOUS SUBSTANCES, AFFECTING HUMANS, 6.2
- ☐ UN2900, INFECTIOUS SUBSTANCES, AFFECTING ANIMALS, 6.2
- ☑ UN3291, REGULATED MEDICAL WASTE, N.O.S., 6.2, PGII
- ☐ UN3291, REGULATED MEDICAL WASTE, N.O.S., 6.2, PGI D/T-SP 11165

GENERATOR'S CERTIFICATION: I hereby declare that the contents of this consignment are fully and accurately described above by proper shipping name and are classified, packed, marked, and labeled, and are in all respects in proper condition for transport by highway according to applicable international and national governmental regulations.

[illegible] — [signature] — 5/20/2014

13. NAME (PRINT/TYPE) SIGNATURE DATE

14. **DESIGNATED FACILITY** NAME AND ADDRESS:
15. PHONE (219) 886 - 3628
16. IL FACILITY ID NO. 9180899333

Stericycle, Inc.
1310 Michigan Street
Gary, IN 46402

17. NAME (PRINT/TYPE) SIGNATURE DATE

18. **ALTERNATE FACILITY** NAME AND ADDRESS:
19. PHONE (217) 935 - 4791
20. IL FACILITY ID NO. 0390050007

Sitelined Stericycle, Inc. 5815 Weldon Springs Rd. Clinton, IL 61727 (217)935-4791 Bob Server

Sitelined Stericycle, Inc 14035 Leenbr Rd Burlington, WI 53177 (262)878-5100 Bill Klug

Jesse Morales — 5/20/14

21. NAME (PRINT/TYPE) SIGNATURE DATE

22. ADDITIONAL INFORMATION: Customer # 0017596 - 001
Remanifested To Manifest #
Trailer #
Containers Transferred To Clinton For Incineration #

Manifest# MDGA007LQ5

23. DISCREPANCIES/CONTINUATION INFORMATION:
Transfer From Vehicle#: ____
PIMW Hauling Permit #: M9025 To Trailer #: ____
Driver Name: ____ License Plate #: ____ State: ____
EMERGENCY TELEPHONE: 1-800-424-9300 Customer No. 21132 Signature: ____ Date: ____

In case of a spill, call Illinois Emergency Management Agency (IEMA) at 800/782-7860 and the National Response Center at 800/424-8802 or 202/426-2675.

COPY 4 - GENERATOR COPY

Printed by Authority of the State of Illinois
IOCI0604-11

IL 520 2072

Stericycle
Protecting People. Reducing
(866) 783-7422

Stericycle (866)783-7422 Route No: 304 - 9

Illinois Environmental Protection Agency

Agency is authorized to require this information under the Illinois Environmental Protection Act, Ill. Rev. Stat., 1989, ch. 111 1/2, pars. 1001 et. seq. ("Act") Section 4 and Public Act 87-752, adding the Act effective January 1, 1992. Disclosure of this information is required. Failure to do so may result in a civil penalty according to Section 42(a) of the Act and a criminal penalty according to Section 44(a) of the Act. This form has been approved by the Forms Management Center.

Illinois Potentially Infectious Medical Waste Manifest

M 4404843

1. **HAULER** NAME AND ADDRESS:
2. PHONE (219) 886 - 3628
3. PIMW HAULING PERMIT M9025
4. LICENSE PLATE [illegible] STATE IN

EMERGENCY TELEPHONE: 1-800-424-9300 Customer No. 21132

Stericycle, Inc.
1310 Michigan Street
Gary, IN 46402

5. NAME (PRINT/TYPE) [illegible] SIGNATURE [illegible] DATE 2/4/2014

6. NUMBER OF CONTAINERS 1 7. TOTAL NET WEIGHT _____ (LBS) _____ (CU. FT.)
8. FEE DUE: LBS x $.03 = _____ 9. Acknowledgement of Fee (Signature)

10. **GENERATOR** NAME AND ADDRESS:
11. PHONE (773) 533-6013

I further declare that this facility has a process or procedures in place designed to prevent inclusion of mercury waste in these materials.

JOSE MORALES
INTERFAITH HOUSE
3456 W FRANKLIN BLVD
CHICAGO, IL 60624-1304

12. TYPE OF WASTE:
- ☐ UN2814, INFECTIOUS SUBSTANCES, AFFECTING HUMANS, 6.2
- ☐ UN2900, INFECTIOUS SUBSTANCES, AFFECTING ANIMALS, 6.2
- ☒ UN3291, REGULATED MEDICAL WASTE, N.O.S., 6.2, PGII
- ☐ UN3291, REGULATED MEDICAL WASTE, N.O.S., 6.2, PGII DOT-SP 11185

GENERATOR'S CERTIFICATION: I hereby declare that the contents of this consignment are fully and accurately described above by proper shipping name and are classified, packed, marked, and labeled, and are in all respects in proper condition for transport by highway according to applicable international and national governmental regulations.

13. NAME (PRINT/TYPE) [illegible] SIGNATURE [illegible] DATE 2/4/2014

14. **DESIGNATED FACILITY** NAME AND ADDRESS:
15. PHONE (219) 886 - 3628
16. IL FACILITY ID NO. 9180899333

Stericycle, Inc.
1310 Michigan Street
Gary, IN 46402

17. NAME (PRINT/TYPE) SIGNATURE DATE

18. **ALTERNATE FACILITY** NAME AND ADDRESS:
19. PHONE (217) 935 - 4791
20. IL FACILITY ID NO. 0390050007

SiteUsed
Stericycle, Inc.
5815 Weldon Springs Rd.
Clinton, IL 61727
(217) 935-4791
Bob Sarver

SiteUsed
Stericycle, Inc.
14035 Lochbir Rd
Sturtevant, WI 53177
(262) 878-5100
Bill King

21. NAME (PRINT/TYPE) SIGNATURE DATE

22. ADDITIONAL INFORMATION:
Customer # 0017596 - 001
Remanifested To Manifest #
Trailer #
Containers Transferred To Clinton For Incineration #

Manifest# MDSA0076LG

23. DISCREPANCIES/CONTINUATION INFORMATION:
Transfer From Vehicle#:
PIMW Hauling Permit #: M9025
Driver Name:
To Trailer #:
License Plate #: State:
EMERGENCY TELEPHONE: 1-800-424-9300 Customer No. 21132 Signature: Date:

In case of a spill, call Illinois Emergency Management Agency (IEMA) at 800/782-7860 and the National Response Center at 800/424-8802 or 202/426-2675.

IL 520 2072

COPY 4 - GENERATOR COPY

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IOCI0604-11

2.4

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	JWCH INSTITUTE, INC. Health & Medical Services	**Effective Date:** July 2010
		Date Revised:
Distribution: All Clinics		**Manual:** Exposure/Infection Control

POLICY

S2: C-1

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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.

Policy#: 0106	JWCH Institute, Inc. Policies & Procedures	Approved By: Dr. P. Gregerson, CMO A. Ballesteros, CEO
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		Date Revised:
Distribution: All Clinics		**Manual:** Exposure/Infection Control

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".

2.1

Stericycle
Hazardous Drug Disposal Service

Stericycle's HDDS Pharmaceutical Identification Checklist

The U.S. Environmental Protection Agency (EPA) requires all businesses to evaluate waste materials prior to disposal in order to determine whether they are regulated as hazardous under the Resource Conservation and Recovery Act (RCRA). This requirement extends to waste pharmaceuticals being disposed of by healthcare facilities, and this process of evaluation and analysis is often referred to as "waste characterization." Stericycle has developed this checklist to assist generators with waste characterization and to ensure that hazardous pharmaceutical waste is accumulated, transported and disposed of properly.

SECTION 1: Identifying Compatible Hazardous Pharmaceutical Waste

Compatible hazardous pharmaceutical waste denotes Rx items that can be placed together in the same container for disposal without risk of a chemical reaction.

CHECK ANY OF THE FOLLOWING THAT YOU CARRY: _____

1. Chemotherapy:
- ☐ Mitomycin, Mitomycin C, Mutamycin
- ☐ Chlorambucil, Leukeran
- ☐ Cyclophosphamide, Cytoxan, Neosar
- ☐ Daunomycin, Daunorubicin, Cerubidin, DaunXome, Rubidomycin
- ☐ Melphalan, Alkeran, L-PAM
- ☐ Streptozotocin, Zanosar
- ☐ Azaserine
- ☐ Diethystilbestrol, DES, Stilphostrol
- ☐ Uramustine, Uracil Mustard, Mustargen

2. Flammables:
- ☑ Mouthwashes
- ☐ Formo Cresol, Cresol Solution
- ☑ Unused/Expired Alcohol Pads, Alcohol Swabs

3. Anesthesia:
- ☐ Sevoflurane, Isoflurane
- ☐ Silvadene, Silver Sulfadiazine
- ☐ PhisoHex
- ☐ Chloroform

4. Vitamins:
- ☑ Glucerna, Boost, Jevity, Nepro, Osmolite, Multigen, POLY-VI-SOL
- ☑ Multivitamins
- ☐ Multigen
- ☐ Protegra
- ☐ Selenium
- ☑ Chromium

5. Vaccines:
Do you vaccinate your patients?
- ☐ Yes
- ☑ No

6. Cardiology:
- ☐ Reserpine
- ☑ Epinephrine*, EpiPen, Epi-Foam, Twinject, Primatene, S2, Adrenaline
- ☑ Nitroglycerine*, Nitrostat, Nitroquick, Nitro-Dur, Nitro-Bid

7. Dermatology:
- ☐ Resorcinol
- ☑ Cough Sprays
- ☑ Afrin
- ☐ Lindane Shampoo or Lotion
- ☐ T-gel, Iniol-T, Polytar, Zetar, Coal Tar
- ☐ Selenium Sulfide, Dandrex, Exsel, Selsun Blue, Selseb, Selenos, Tersi Foam
- ☐ Fluocinonide Topical, Lidex
- ☐ Fluorescein Sodium
- ☑ Lice Treatment Shampoos, Nix

8. Ophthalmology:
- ☐ Neo-Synephrine
- ☑ Vision Blue, Trypan Blue
- ☐ FML S.O.P, Fluoromethalone
- ☐ Neomycin/Polymyxin/dexamethazone
- ☐ Viroptic, Trifluridine
- ☐ Blephamide

9. Diabetes Treatment:
- ☑ Humalog, Humulin
- ☐ Novolog, Novolin
- ☐ Symlin
- ☐ Levemir
- ☐ Iletin
- ☐ Byetta
- ☑ Insulin

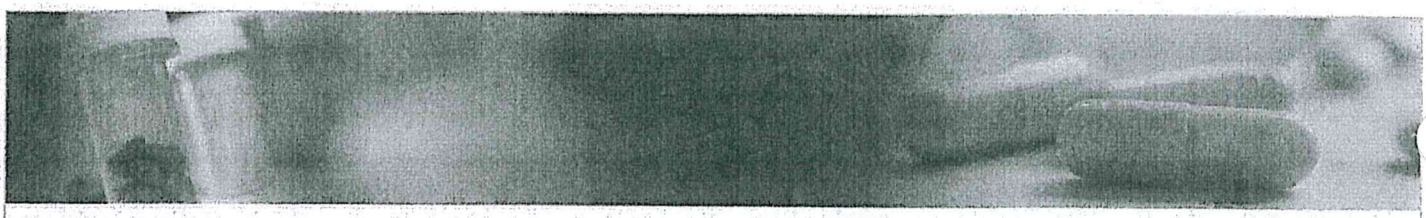
SECTION 2: Identifying P-Listed Hazardous Pharmaceutical Waste

P-listed hazardous waste, also known as "acutely hazardous waste," is subject to a special set of EPA regulatory requirements due to its high toxicity to human health and the environment. P-listed Rx waste must be collected separately from other Rx waste and monitored so that the total amount on-site does not exceed 2.2 pounds.

CHECK ANY OF THE FOLLOWING THAT YOU CARRY: _____

- ☑ Coumadin/Jantoven/warfarin
- ☑ Nicotine patches, lozenges & gums
- ☐ Physostigmine, Physostigmine Salicylate
- ☐ Arsenic Trioxide/Trisenox

* In the vast majority of states, medical-grade nitroglycerine and epinephrine are exempted from P-listed status.



SECTION 3: Identifying Incompatible Hazardous Pharmaceutical Waste

A small number of medications, known as "incompatible" pharmaceutical waste, must be collected and transported in their own containers, separate from compatible waste and from one another, to prevent a chemical reaction from occurring. Following is a list of incompatible pharmaceuticals. **Please note that each underlined category listed below requires its own container, separate from all other Rx waste.**

CHECK ANY OF THE FOLLOWING THAT YOU CARRY: _____

- ☑ Aerosols (includes asthma inhalers, Hurricane)
- ☐ Botox/Myobloc
- ☐ Collodion/nitrocellulose (includes New Skin, wart removers)
- ☑ Corrosive Acids (includes aluminum chloride injections, Tri-Chlor, ammonia inhalants, cupric/copper/chromium chloride, hydroxyzine hydrochloride, L-Cysteine, lactic acid, Pyridoxine HCL injection, Sporanox)
- ☐ Oxidizers (includes Silver Nitrate sticks/applicators, Arxol Silver, Amyl Nitrate, Cyanide Antidote kits)

SECTION 4: Estimating Pharmaceutical Waste Volume

Thinking of a typical office/desk-side trash can (approximately 8 gallons and roughly 12" diameter x 18" high), how often would it take you to fill with pharmaceutical waste (excluding controlled substances)?

- ☐ One Week or less
- ☐ One Month
- ☐ Three Months
- ☑ Six Months
- ☐ Twelve Months

SECTION 5: Definition of Acceptable Pharmaceutical Waste

I certify that these containers will be used only for collection of RCRA hazardous and non-hazardous pharmaceutical waste. I certify that no DEA controlled substances, infectious or regulated medical wastes (RMW) or non-pharmaceutical wastes of any kind will be included in these containers. I certify that I will collect my incompatible pharmaceutical waste separately from my compatible pharmaceutical waste. I agree to place only wastes conforming to these descriptions into these containers.

Name: Pam Kerr Signature: _____ Position/Title: Assistant

Date: 11-10-2014 Phone: (773) 533-6013 Fax: (773) 533-9034 Email: p.kerr@interfaithhouse.org

System Name/Affiliation: Interfaith House

Facility Name: Interfaith House Facility Address: 3456 W Franklin Blvd

Facility City/State/Zip: Chicago, IL 60624-1308

Customer Number: 0017596

Site ID: 001

Jennifer Pyster

847-943-6446

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YAKIMA NEIGHBORHOOD HEALTH SERVICES
Waste Management Plan

It is the procedure of Yakima Neighborhood Health Services (YNHS) to maintain a waste management system that identifies types of waste, how to handle, store, and appropriately dispose of all waste according to current standards of applicable governing agencies that regulate hazardous materials and waste.

Definitions:

Regulated waste includes:
Regulated waste refers to liquid or semi-liquid blood or other potentially infectious materials; items contaminated with blood or other potentially infectious material that would release these substances in a liquid or semi-liquid state if compressed; items caked with dried blood or other potentially infectious materials and are capable of releasing these materials during handling.
Pathological and microbiological wastes containing blood or other potentially infectious material.
Other Potentially Infected Material such as:

Cerebrospinal fluid

Pleural fluid

Synovial fluid

Pericardial fluid

Peritoneal fluid

Amniotic fluid

Vaginal secretions

Semen

Saliva in dental procedures

Any unidentified fluid that could contain blood

Sharps: Devices with physical characteristics capable of puncturing, lacerating, or otherwise penetrating the skin and are contaminated. Included in this definition are any sharps used in patient care such as

hypodermic needles,

syringes (with or without needles attached),

scalpel blades,

test tubes,

blood vials,

broken or unbroken glass which may have been in contact with blood or other infectious materials.

Solid waste includes:

Gloves

Dip sticks

Cotton balls

Band-Aids

Cath tubes (if not labeled with PHI)

IV tubing (if not labeled with PHI)

Chucks

And all other waste not classified regulated (see miscellaneous waste)

NOTE: If any of the items listed as solid waste become contaminated following the definition in #1, they must then be considered regulated waste.

Point of origin: The room or area where the waste is generated. Examples include
exam rooms,
procedure rooms and
operatories

Handling of Waste

Inspect and decontaminate, on a regular basis, reusable receptacles such as bins, pails, and cans that have the likelihood for becoming contaminated. When contamination is visible, clean and decontaminate receptacles immediately, or as soon as feasible.
Always use mechanical means, such as tongs, forceps, or a brush and a dustpan to pick up contaminated broken glassware; never pick up with hands even if gloves are worn.
Place regulated waste in a closable and labeled, or color-coded, container. When storing, handling, transporting, or shipping, place regulated waste in containers that are constructed to prevent leakage.
When discarding contaminated sharps, place them in containers that are closable, puncture resistant, appropriately labeled or color-coded and leak proof on the sides and bottom.
Ensure that sharps containers are easily accessible to personnel and located as close as is feasible to the immediate area where sharps are used or can be reasonably anticipated to be found. Sharps containers also must be kept upright throughout use, replaced routinely, closed when moved, and not allowed to overfill.
Never manually open, empty, or clean reusable contaminated sharps disposal containers.
Handle contaminated laundry as little as possible and with minimum of agitation.
Use appropriate personal protective equipment (ppe) when handling contaminated laundry.
Bag wet and/or contaminated laundry in a red bio bag, at its point of origin, before transporting.
Never sort or rinse contaminated laundry in areas of use.
Labels may not be required when
red bags or red containers are used,
containers of blood, blood components, or blood products are labeled as to their contents and have been released for transfusion or other clinical use, and
individual containers of blood and other potentially infectious materials are placed in a labeled container during storage, transport, shipment, or disposal.

Waste Disposal

Regulated biohazardous waste
All non-sharp regulated waste is to be segregated from solid waste at its point of origin and deposited into containers lined with a red biohazard bag, identified with a biohazard symbol and the word BIOHAZARD.
All waste items classified as sharps should be placed immediately into puncture resistant, leak-proof containers.
Staff who participate in regulated waste disposal procedures should be trained in said procedures by staff versed in the process.
Regulated non-sharps biohazardous waste container procedure:
Regulated waste containers are disposed of on a regularly scheduled basis.

1. Designated staff prepare biohazard containers for use and disposal. This may include labeling, preparing the box and bag and removal to temporary storage. (See Appendix C, Infectious Waste Container Tracking Log). (See Appendix P, YNHS INFECTIOUS WASTE TRACKING STICKERS)

2. Storage of regulated waste must be in an area away from general traffic flow patterns and accessible only to authorized personnel.

3. Regulated waste should be disposed of following federal, state and local regulations.

4. Verification of disposal should be obtained.

Other waste requiring special handling:

Other waste requiring special handling is collected, stored, and labeled appropriately. Hazardous waste should be disposed of with approved Hazardous Waste Disposal sites/companies.

a) Amalgam (See Appendix Z, HANDLING, STORAGE AND DISPOSAL OF SCRAP AMALGAM)

b) Batteries: Used household, watch and cellular phone batteries can be disposed of in designated white buckets labeled Battery Recycling located. Once filled, contact the Facilities Assistants who will arrange for disposal and replacement bucket.

c) Lead: Lead aprons that are cracked or fail annual testing are disposed of at the Yakima County Hazardous Wasted Disposal site.

d) Light bulbs:

(1) Includes, but is not limited to, all types of fluorescent lamps, mercury vapor, metal halide, high-pressure sodium and neon lamps.

(2) Dispose of at Yakima County Hazardous Waste Facility

e) Mercury:

(1) Obtain Mercury spill kit.

(2) Follow the manufacturer's directions for protective equipment and disposal.

f) Expired or returned medications (see Medication Management Guidelines for proper handling and disposal)

g) Other chemicals are disposed of per manufacturer or SDS guidelines.

Biohazard spill clean-up procedure:

Surfaces contaminated with spilled or leaked biohazardous waste will be cleaned using absorbent materials and the surface disinfected per protocol (See Appendix D, HAZARDOUS SPILL CLEANUP PROCEDURE).

Biohazard sharp container procedure:

YNHS sharp containers are wall mounted or portable and designated with a Biohazardous label. Sharp containers are to be disposed of when fill line is reached. They are to be locked and disposed of in a biohazard waste container.

Solid Waste Disposal

Universal precautions to be observed.
Wear gloves
Hold away from your body
Use a "garden claw" or other tool to compact solid waste. Do not crush down with your hands
Wash hands after disposing
Solid waste placed in secured location and removed by contracted waste disposal company per agreement.

Excerpted from Safety and Emergency Management Guide

~~2.2~~

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	JWCH INSTITUTE, INC. Health & Medical Services 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.

~~2~~ 2.2

S2: C-2 (pg 3 of 4)
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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

TOPIC: MEDICATION, ADMINISTRATION OF

PURPOSE: To set forth clinical standards and procedures for administering medication via oral or subcutaneous/intramuscular routes.

LEVEL OF RESPONSIBILITIES:

All Clinical Staff

POLICY: PCC recognizes that many staff are qualified to administer medications, however all medication must be administered under a written order by a provider and staff other than licensed nurses must administer medications under the direct supervision of a provider. In addition, PCC recognizes that due to the large number of medications used in healthcare, it is imperative that staff take steps to minimize the potential for error whenever possible. PCC is committed to taking measures to minimize such failures by releasing a list high-alert medications as well as look alike/sound alike medications used at PCC and additional precautions to take when administering them.

PROCEDURE:

1. Providers order medication including dose and route; this order must be in writing on encounter. Provider reviews contraindications and potential reactions to medications with patient.

2. Staff members preparing and administering medication will address the "rights" of medication administration:
    - Right patient
    - Right medication
    - Right dosage
    - Right route
    - Right time

These "rights" are followed for all patients receiving medications for all possible routes each and every time.

3. General clinical actions will include:
    - After checking the order, read the label three times while preparing the drug: while medication is on the shelf, again while removing the patient dose, and again when returning container to shelf when multi-dose vial is used.
    - Inspect each medication evaluating the integrity of the medication and expiration date. If any cloudiness, sediment, or particles are found or the medication is expired, medication should not be used and a site Manager should be notified.
    - Place each medication in a separate container or label each syringe separately if more than one injection must be given.
    - Refer to package insert for specific guidelines as needed.

2.1

Stericycle Specialty Waste

Service Agreement: Hazardous Drug Disposal Service

"Parties"							
"Customer"				"Stericycle Specialty Waste"			
Billing Name	Interfaith House			Name	Stericycle Specialty Waste Solutions, Inc.		
Billing Address	3456 W Franklin Blvd			Address	4010 Commercial Ave		
Billing City, St, Zip	Chicago, IL 60624-1308			City, St Zip	Northbrook, Il 60062		
Billing Phone	(773) 533-6013	Billing Fax	773) 533-9034	Phone	847-943-6446	Fax	(773) 533-9034

Agreement Effective Date: 03/01/2015 **Term of Agreement ("Initial Term"):** 24 Months

Terms and Conditions

This Service Agreement ("Agreement") between the Parties (specified above) shall apply to all goods ("Supplies") and services provided by Stericycle Specialty Waste Division (SSWSI) to Customer at the Service Location(s) provided in Schedule B and shall automatically renew for successive terms equal to the Initial Term unless either of the Parties has given written notice of termination at least 60 days prior to termination of the Initial Term or any successive term. Customer's Waste Profile(s), analytical testing, MSDS(s), reports of process generating waste, proposals and other information provided are hereby incorporated. Customer authorizes SSWSI to prepare, execute and submit additional applications required to manage Customer's Waste. Customer understands that all items to be transported are to be offered in accordance with the requirements of 49 CFR subparts 100-185 or Customer agrees to pay Overpack or added labor charges, as necessary, to conform to these requirements. Items offered for transportation must be free of Hazardous residue on external surfaces and be properly segregated to meet U.S. Department of Transportation requirements. All Terms and Conditions, except item 1 below, shall survive this Agreement's termination.

1. Customer agrees that while this Agreement is in effect, SSWSI has the exclusive right to provide: (a) the Supplies and service(s) described in Schedule A, and (b) all other Supplies and services provided to Customer by SSWSI during the time beginning with the Agreement Effective Date until this Agreement is terminated.
2. If Customer breaches this Agreement by terminating SSWSI's service prior to the expiration of its Term or any Extension Term, or in any other way violates this agreement in such a way that SSWSI's continued performance is rendered impossible or commercially impracticable, then, in addition to any rights and remedies SSWSI may have at law or in equity, SSWSI shall be entitled to collect from Customer an amount in liquidated damages equal to fifty (50) percent of Customer's average charge on a monthly basis based on the twelve (12) months' billings prior to the cessation of collections (or based on any lesser period if the contract began less than twelve months earlier) multiplied by the number of months remaining until the expiration date of the Term or Extension Term. Customer hereby acknowledges that SSWSI's damages resulting from the premature termination of collections are impossible of estimation and include lost profits, inefficiencies resulting from route changes, increased administrative overhead, unrecoverable sunk training/instruction costs and other elements of injury, and acknowledges further that the foregoing charge is reasonable and is not a penalty.
3. SSWSI reserves the right to adjust the contract price to account for operational changes it implements to comply with changes in law, to cover increases in the cost of fuel, insurance, or residue disposal, or to otherwise address cost escalation. SSWSI may charge Customer a fee to cover its administrative costs in the event that Customer changes its service requirements during the Term or Extension Term.
4. Customer is responsible for and shall pay for all damage(s) to SSWSI's equipment or SSWSI's Subcontractor's equipment caused by Customer or Customer's Contractor.
5. Customer agrees that SSWSI shall have the option to utilize Subcontractors to provide the Supplies and services contemplated by this Agreement.
6. SSWSI's performance shall be contingent on the TSDF's approval of Customer's Waste. SSWSI shall be excused from performance in the event its Contractor or TSDF becomes unavailable to SSWSI for any reason.
7. **Health Insurance Portability and Accountability Act (HIPAA):** SSWSI agrees to use and disclose Protected Health Information in compliance with the Standards for Privacy of Individually Identifiable Health Information ("Privacy Rule") (45 C.F.R. Parts 160 and 164) under the Health Insurance Portability and Accountability Act of 1996. The definitions set forth in the Privacy Rule are incorporated by reference into this Agreement (45 C.F.R. §§ 160.103 and 164.501).
8. **Payment terms are net 30 days from invoice date.** A finance charge equal to 18% per annum, or the maximum amount permitted by law shall be charged to overdue invoices. SSWSI may terminate this Agreement at any time for non-payment. Customer agrees that all monetary disputes related to services provided during this Agreement or after this Agreement is terminated, may, at SSWSI's sole election, be submitted to binding arbitration in the State of Illinois under the rules of the American Arbitration Association. SSWSI shall be entitled to payment equal to costs incurred in collecting payment from Customer including reasonable attorney fees and collection fees ($500 minimum).
9. Customer agrees to offer only Conforming Waste(s) to SSWSI. Customer agrees to notify SSWSI in the event the character and/or process that generates the Waste changes and, if so, submit a new Waste Profile to SSWSI for that Waste. Customer also agrees to provide SSWSI with analytical testing as periodically required by SSWSI to confirm that Customer's Waste(s) are Conforming Waste(s).
10. Customer shall pay or reimburse SSWSI for any and all expenses, fines, analytical fees, clean-up expenses, transportation fees, storage fees, disposal fees, and reasonable attorney fees incurred by SSWSI, SSWSI's Subcontractor, or TSDF as a result of Customer's breach of any provision of this Agreement, including, but not limited to, Customer offering Waste that is not Conforming Waste, whether before, on or after the Initial Term or any successive term of this Agreement, to SSWSI, SSWSI's Subcontractors, or TSDF.
11. This Agreement will be binding upon and inure to the benefit of the Parties and their respective successors and assigns.
12. **Title and Risk of Loss to Conforming Waste:** Title and Risk of Loss to Conforming Waste (excluding Waste that is land disposed or land applied) shall be vested in SSWSI at such a time as it is loaded onto vehicle(s) of SSWSI or SSWSI's Subcontractor(s) until such a time that SSWSI or SSWSI's Subcontractor(s) delivers said Conforming Waste to the TSDF(s), then Title and Risk of Loss shall transfer to TSDF(s). SSWSI warrants that SSWSI shall only deliver Customer's Waste to TSDF(s) with whom SSWSI has a written contractual relationship whereby Title and Risk of Loss for Conforming Waste transfers to the TSDF(s), upon delivery, of said Conforming Waste from SSWSI or SSWSI's Subcontractor(s), to the TSDF(s).

    Title and Risk of Loss to Customer's Waste that is not Conforming Waste ("Non-Conforming Waste"): Title and Risk of Loss to Customer's Waste that is not Conforming Waste("Non-Conforming Waste") shall remain with Customer, until the required steps have been taken to develop i.) an accurate Waste Profile, ii.) an accurate shipping manifest(s), and iii.) accurately labeled containers, to meet Federal, state and local laws and regulations. Once all discrepancies have been resolved, and the Customer's Non-Conforming Waste is rendered Conforming Waste, Title and Risk of Loss for said Waste shall be vested in SSWSI in accordance with the terms specified under **Title and Risk of Loss to Conforming Waste** above. SSWSI may, solely as an accommodation to Customer, and at the Customer's sole additional expense, assist in resolving said discrepancies and/or arrange for the proper handling, storage, and transportation of such Waste in accordance with applicable Federal, state and local laws and regulations, until such a time that the Non-Conforming Waste has been rendered Conforming Waste or has been returned to the Customer or Customer's designee. SSWSI shall exert reasonable care in the storage and handling of Customer's Non-Conforming Waste.

By signing below, I acknowledge that I am Customer's authorized officer or agent and have the authority to bind Customer to this Agreement. Customer agrees to be bound by the Terms and Conditions hereof including the Supplementary Definitions and other information provided in Schedule A.

Customer

Signature

Name (Please Print)

Title / Date Signed

SSWSI

Signature

Name (Please Print)

Title / Date Signed

2.1

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.	JWCH INSTITUTE, INC. Health & Medical Services	**Effective Date:** July 2010
		Date Revised:
Distribution: All Clinics		**Manual :** Dispensary

S2: C-4

Click here to return to Standards Page

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.

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.

2.3

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	JWCH INSTITUTE, INC. Health & Medical Services	**Effective Date:** July 2010
		Date Revised:
Distribution: All Clinics		**Manual :** Dispensary

POLICY

S2: C-1

Click here to return to Standards Page

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.

medication

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.

Yakima Neighborhood Health Services

MRSA Guidelines

YNHS recognizes the need to adhere to good infection control standards in order to prevent the spread of community acquired MRSA. As such, the following procedures should be followed when a patient with a known MRSA infection is seen at YNHS:

Standard Precautions include:

- Perform **hand hygiene** before and after each patient contact. This may consist of an alcohol-based hand sanitizer if hands are not visibly soiled or soap and water.
- **Mask coughing patients**; if coughing patient is unable to mask, or when performing a respiratory exam, the healthcare worker, including provider, should wear a mask with eye protection.
- After glove removal and hand hygiene, do not touch potentially contaminated environmental surfaces or items in the patient's room to avoid transfer of microorganisms to other patients and environments.
- Use **barrier protective coverings** as appropriate for noncritical surfaces that are
  1. touched frequently during the delivery of patient care
  2. likely to become contaminated with blood or body substances
  3. difficult to clean

Contact Precautions include:

- Wear **gloves** when touching non-intact skin or mucous membranes, visibly soiled linen, or visibly soiled equipment and surfaces.
- **Gown** if body contact with patient or contaminated secretions is anticipated
- Wear gloves, gown, and **face protection** (surgical mask with eye shield) when performing wound care procedures: irrigating, debriding, performing I & D, or working with complex wounds.
- Discard gloves/gown and perform hand hygiene immediately before leaving exam room.
- Minimize environmental contamination through use of environmental barriers (blue pads, trash bags).
- Do not close room down when patient is discharged.

Environmental Cleaning

- Use an EPA registered cleaner/disinfectant for environmental cleaning and follow manufacturer's instructions for use. Do not use alcohol alone to disinfect the environment or equipment.
- Wear gloves when cleaning/disinfecting the environment. Always perform hand hygiene after removing gloves.
- Wear gown if clothing is likely to be soiled during the cleaning process.
- Wipe thoroughly all environmental surfaces touched by patient or staff during encounter with a disinfectant and allow to air dry.
- If surface has visible body substance contamination: clean surface, discard towel, re-wipe or spray with disinfectant, and let dry.
- Change cleaning cloths (paper towel or wipes) frequently between surfaces.
- Room may be used immediately after cleaning/disinfecting environmental surfaces.

Equipment and Supplies

- Perform hand hygiene prior to accessing clean and sterile supplies to prevent cross contamination of supplies.

• Clean all equipment touched by patient and staff with an approved disinfectant.
• Disinfect or sterilize, as appropriate, all reusable items immediately after use and prior to storage (includes bandage scissors).
• Discard unused contaminated disposable supplies, i.e., unopened supplies on a used procedure tray.

Trash and Laundry
• Contain trash and laundry at the point of use.
• Discard soiled cloth laundry in a fluid resistant laundry hamper or plastic bag.
• Discard disposable paper sheets and gowns in regular trash

For additional information on infection control, see:
- CDC. Information About MRSA for Healthcare Personnel http://www.cdc.gov/ncidod/dhqp/ar_mrsa_healthcareFS.html
- CDC. Management of Multidrug-Resistant Organisms In Healthcare Settings, 2006. Siegel JD, et al; the Healthcare Infection Control Practices Advisory Committee. http://www.cdc.gov/ncidod/dhqp/pdf/ar/mdroGuideline2006.pdf
- What to do about MRSA Toolkit for Outpatient Clinics/Medical Offices (Handbook and wall charts on infection control included), http://.www.tpchd.org/mrsa:

Reference:
Guidelines for Evaluation & Management of Community-Associated Methicillin-Resistant Staphylococcus aureus Skin and Soft Tissue Infections in Outpatient Settings, December 2007

Yakima Neighborhood Health Services
Pertussis Management

Pertussis is an acute bacterial infection of the respiratory tract that is caused by *Bordatella pertussis*, a gram- negative bacterium. *B. pertussis* is a uniquely human pathogen that is transmitted from an infected person to susceptible persons, primarily through aerosolized droplets of respiratory secretions or by direct contact with respiratory secretions from the infected person.

YNHS recognizes its role in the prevention of the acquisition and transmission of this disease. Toward this end, YNHS promotes vaccination of susceptible persons as recommended by the CDC and ACIP, and recognizes the CDC as a valuable source of recommendations regarding the management and treatment of this disease.

A Pertussis Screening Form, based on the 2005 CDC recommendations regarding antimicrobial agents for the treatment and postexposure prophylaxis of pertussis and guidelines for the control of pertussis outbreaks is available for use in appropriate clinical situations. When a client is identified as being exposed to and/or is identified as a close contact of a confirmed case of pertussis, a clinic nurse utilizes the Pertussis Exposure Screening Form in order to come to an appropriate disposition for that client.

IMPLEMENTATION OF CONTROL MEASURES

Control measures should be implemented when one or more cases of pertussis is recognized at YNHS. Confirmed cases should be reported to the Yakima Health Department.

IDENTIFYING AND INVESTIGATING CASES AND CONTACTS

A clinical case is defined as a cough illness lasting at least 2 weeks with one of the following: paroxysms of coughing, inspiratory "whoop," or post-tussive vomiting, and without other apparent cause (as reported by a health professional).

YNHS EMPLOYEES

YNHS employees should be considered exposed and regarded as close contacts if the source is a confirmed case or if the source is a suspected case during an outbreak.

Centers for Disease Control and Prevention case definition for pertussis
A clinical case is defined as a person: Who has a cough illness lasting at least two weeks with one of the following: paroxysms of coughing, inspiratory "whoop," or posttussive vomiting, and without other apparent cause (as reported by a health professional)

The laboratory criteria for diagnosis are:
The isolation of Bordetella pertussis from a clinical specimen, or
Positive polymerase chain (PCR) reaction assay for B. pertussis

A confirmed case is defined as a person:
With an acute cough illness of any duration who is culture positive from nasopharyngeal secretions who meets the clinical case definition (see text) with laboratory confirmation by PCR from

nasopharyngeal secretions who meets the clinical case definition (see text) and is epidemiologically linked directly to a case confirmed by either culture or PCR from nasopharyngeal secretions

A probable case is defined as a person:
Who meets the clinical case definition (see text) without laboratory confirmation or an epidemiologic link to a laboratory-confirmed case.

Close contact includes activities such as performing a physical examination, suctioning, intubation, feeding, bathing, and other procedures requiring prolonged or close interaction. YNHS employees working with pediatric patients should be considered at high risk of exposure to pertussis. YNHS employees should wear masks when examining a patient with suspected or confirmed pertussis. If health care workers contract pertussis they will become high risk cases because of their high probability of exposing susceptible individuals who have an increased risk of morbidity.

If exposed to a case of pertussis, YNHS health care personnel should be questioned about symptoms of cough illness and should be counseled to report the development of symptoms consistent with pertussis to infection control staff or supervisor. All symptomatic health care workers should be tested for pertussis by culture as soon as possible. Health care workers should be aware that individuals are highly contagious even during the catarrhal phase of pertussis illness.

Exclusion

See algorithm for treatment and furlough guidelines for exposed or potentially exposed health care workers.

NON-EMPLOYEE PATIENTS

Patients should be considered exposed and regarded as close contacts only if the source is a confirmed case or if the source is a probable case during an outbreak. Close contact includes patients who have shared a room or common living space with a pertussis case, or patients who have been directly cared for by a health care worker with pertussis.

In general, most individuals who were in waiting rooms or other areas at the same time as a pertussis case should not be considered close contacts. Patients and caretakers who had direct contact with respiratory secretions from the case, or who had intense close contact (e.g. playing with a pertussis case in the waiting room for an extended period of time) may be considered close contacts. Patients who were in direct contact with respiratory secretions from a symptomatic health care worker with pertussis or who received direct care of an extended nature (e.g., a complete physical exam) from a symptomatic health care worker with pertussis should be considered close contacts. High risk contacts (e.g., young infants, unimmunized children) who received any care from a health care worker with pertussis or had extensive contact with a suspected case should be considered close contacts.

When it is known that a symptomatic contact or known infectious pertussis case will be coming to YNHS, steps should be undertaken to ensure that significant exposure to other patients and staff members is minimized. The patient should politely and discreetly be asked to put on a mask and

escorted to a negative airflow room, avoiding highly populated areas of the clinic. YNHS employees should wear masks when examining a patient with suspected or confirmed pertussis.

Symptomatic patients should have a nasopharyngeal specimen taken for culture as soon as pertussis is suspected.

Close contacts (or their care-givers) should be notified of the exposure to pertussis and be instructed to report to their medical provider any symptoms consistent with pertussis that develop within 21 days of the last clinic exposure.

Vaccination

All contacts less than or equal to 6 years of age who have not completed the four-dose series should complete the series with the minimum intervals. Children aged 4-6 years who have completed the primary series but have not received the pertussis vaccination booster should receive this dose.

Exclusion

Symptomatic patients should be placed in isolation and on droplet precaution for the first 5 days of a full course of antimicrobial treatment. Symptomatic patients who cannot or refuse to take antimicrobial treatment should be placed in isolation for 21 days from onset of cough. Suspect and confirmed pertussis patients should be advised that they are infectious until they have completed the first 5 days of their antimicrobial treatment or until 21 days has elapsed from onset of cough (for those who cannot take or refuse antimicrobial treatment).

TREATMENT

Antimicrobial treatment should be initiated as soon as pertussis is suspected in a patient or health care worker. The choice of antimicrobial agent to use should be based on current CDC recommendations. Initiating treatment greater than or equal to 3 weeks after cough onset has limited benefit to the patient or contacts. However, treatment is recommended up to 6 weeks after cough onset in high risk cases.

POST-EXPOSURE PROPHYLAXIS

Postexposure prophylaxis — Postexposure antibiotic prophylaxis is warranted for individuals with close contact to a person with pertussis. A close contact is defined as a person who has had face-to-face exposure within three feet of a symptomatic patient. Individuals with direct contact with respiratory, nasal or oral secretions may also be considered close contacts. The threshold to administer postexposure antibiotics may be lower in certain groups with high risk for morbidity and mortality including infants and individuals with chronic lung disease and immunodeficiency. The antibiotic regimens for postexposure prophylaxis are identical to those used for the treatment of pertussis (see table). Administration of postexposure therapy to asymptomatic contacts within 21 days of onset of cough in the index patient can prevent symptomatic infection.

Recommended antimicrobial treatment and postexposure prophylaxis for pertussis, by age group

Age group	Primary agents			Alternate agent*
	Azithromycin	Erythromycin	Clarithromycin	TMP-SMX
<1 month	Recommended agent. 10 mg/kg per day in a single dose for 5 days (only limited safety data available)	Not preferred. Erythromycin is associated with infantile hypertrophic pyloric stenosis. Use if azithromycin is unavailable; 40 to 50 mg/kg per day in 4 divided doses for 14 days	Not recommended (safety data unavailable)	Contraindicated for infants aged <2 months (risk for kernicterus)
1-5 months	10 mg/kg per day in a single dose for 5 days	40 to 50 mg/kg per day in 4 divided doses for 14 days	15 mg/kg per day in 2 divided doses for 7 days	Contraindicated at age <2 months. For infants aged ≥2 months, TMP 8 mg/kg per day, SMX 40 mg/kg per day in 2 divided doses for 14 days
Infants (aged ≥6 months) and children	10 mg/kg in a single dose on day 1 (maximum: 500 mg); then 5 mg/kg per day (maximum: 250 mg) on days 2 through 5	40 to 50 mg/kg per day (maximum: 2 g per day) in 4 divided doses for 14 days	15 mg/kg per day in 2 divided doses (maximum: 1 g per day) for 7 days	TMP 8 mg/kg per day, SMX 40 mg/kg per day in 2 divided doses for 14 days
Adults	500 mg in a single dose on day 1 then 250 mg per day on days 2 through 5	2 g per day in 4 divided doses for 14 days	1 g per day in 2 divided doses for 7 days	TMP 320 mg per day, SMX 1600 mg per day in 2 divided doses for 14 days

TMP-SMX: Trimethoprim-sulfamethoxazole.

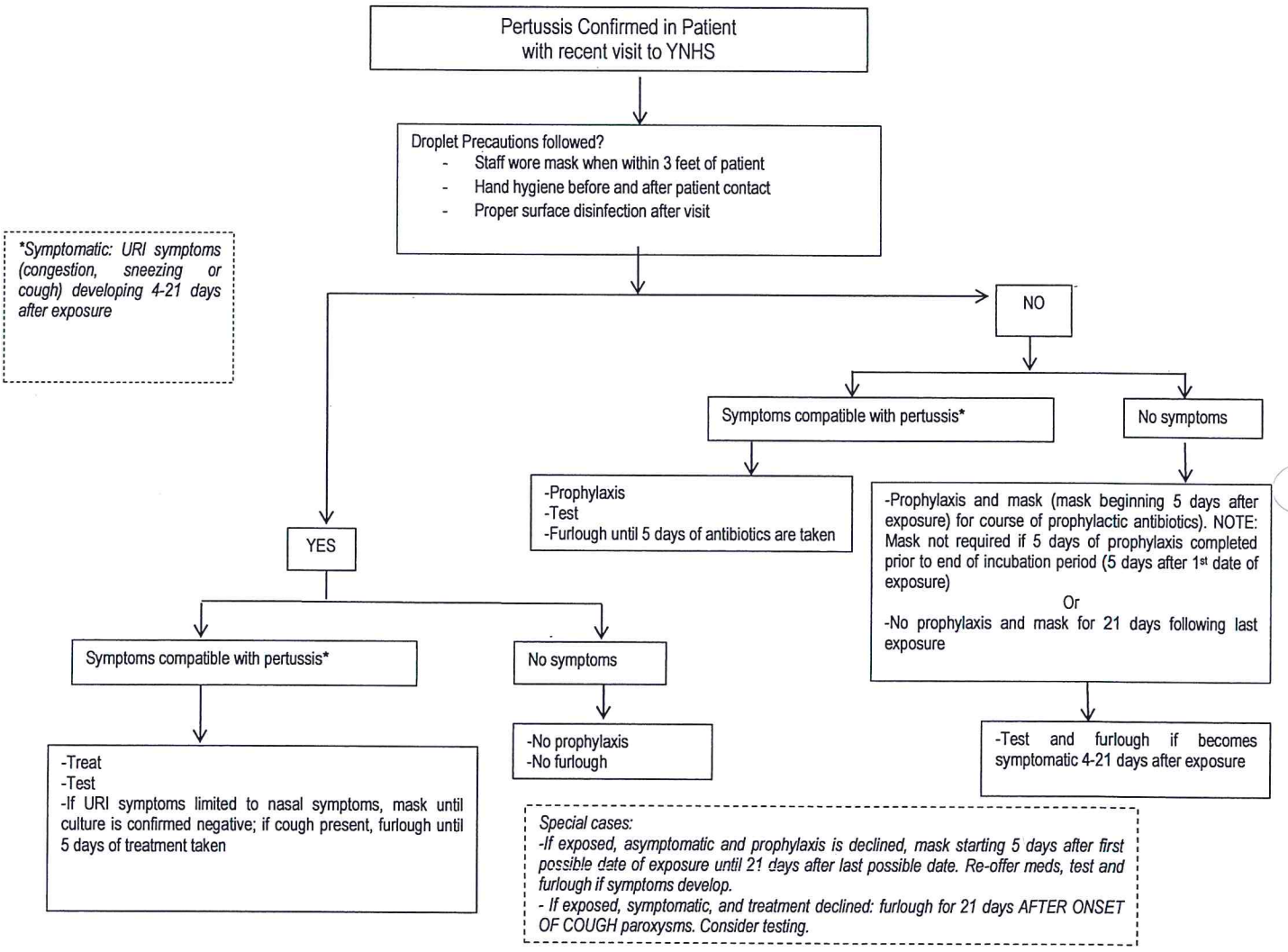
* TMP-SMX can be used as an alternative agent to macrolides in patients aged ≥2 months who are allergic to macrolides, who cannot tolerate macrolides, or who are infected with a rare macrolide-resistant strain of *Bordetella pertussis*.

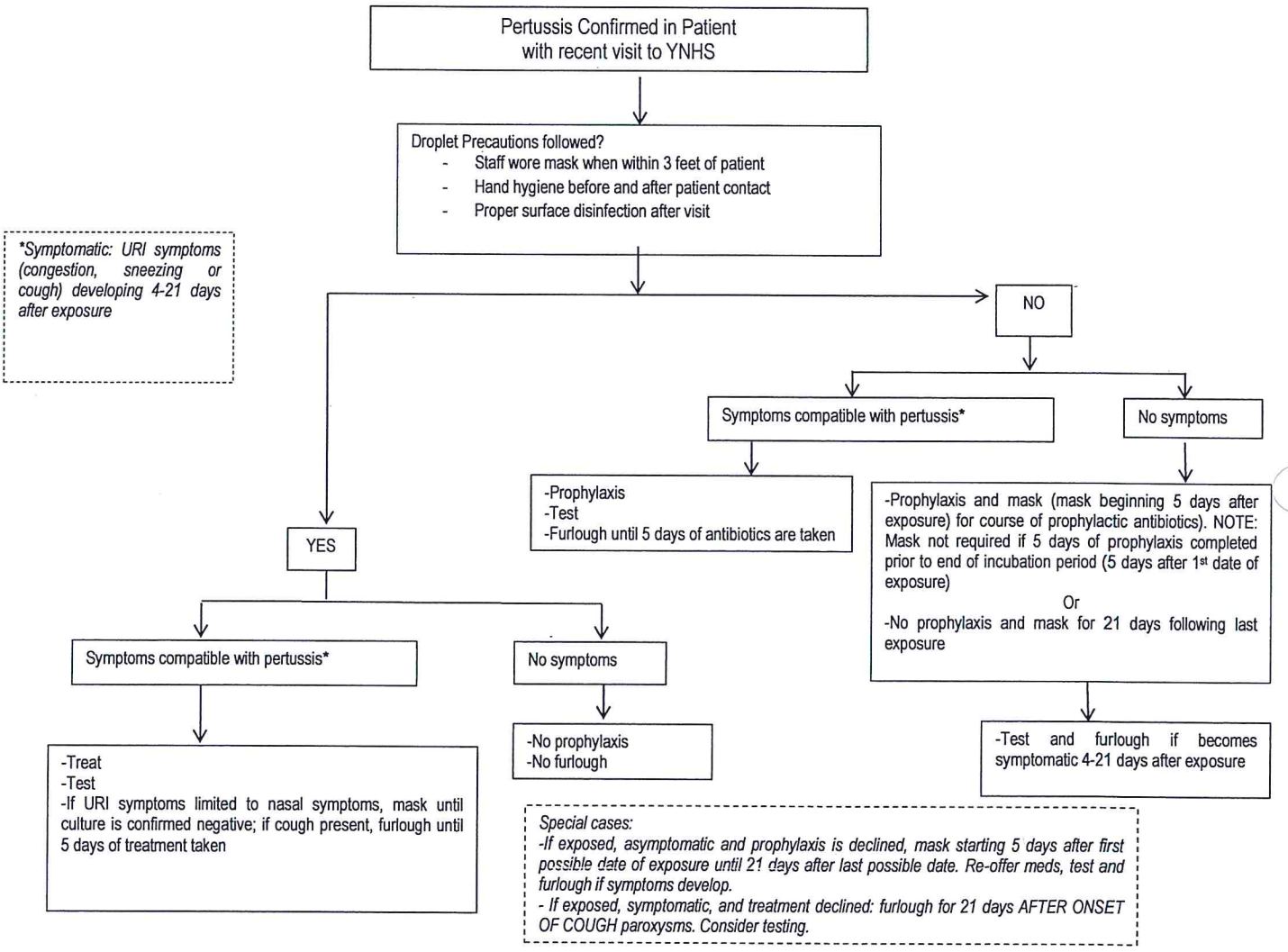
Centers for Disease Control and Prevention. Recommended antimicrobial agents for the treatment and postexposure prophylaxis of pertussis. 2005 CDC guidelines. MMWR 2005; 54:10.

Exposed individuals, especially those with an incomplete vaccination history, should be closely observed for symptoms and signs of pertussis for three weeks after contact. Postexposure immunization, either passive with immunoglobulin or active with pertussis vaccine, does not protect contacts from infection. *(http://www.uptodate.com/contents/treatment-and-prevention-of-bordetella-pertussis-infection-in-adolescents-and-adults?source=machineLearning&search=pertussis+prophylaxis&selectedTitle=1~150&sectionRank=2&anchor=H12882723#H12882723)*

SURVEILLANCE

It is the goal of YNHS to minimize the exposure of its patients and staff members to known cases of pertussis or to symptomatic contacts of pertussis cases. When YNHS staff is alerted to the planned arrival of a known infectious pertussis case or a symptomatic contact (e.g., via communication from the Yakima Health Department or other medical practitioner), a clinic nurse should be notified in order to facilitate proper handling of the situation.


Pertussis Confirmed in Patient with recent visit to YNHS
Droplet Precautions followed?
- Staff wore mask when within 3 feet of patient
- Hand hygiene before and after patient contact
- Proper surface disinfection after visit
*Symptomatic: URI symptoms (congestion, sneezing or cough) developing 4-21 days after exposure
YES
NO
Symptoms compatible with pertussis*
No symptoms
-Prophylaxis
-Test
-Furlough until 5 days of antibiotics are taken
-Prophylaxis and mask (mask beginning 5 days after exposure) for course of prophylactic antibiotics). NOTE: Mask not required if 5 days of prophylaxis completed prior to end of incubation period (5 days after 1st date of exposure)
Or
-No prophylaxis and mask for 21 days following last exposure
Symptoms compatible with pertussis*
No symptoms
-Treat
-Test
-If URI symptoms limited to nasal symptoms, mask until culture is confirmed negative; if cough present, furlough until 5 days of treatment taken
-No prophylaxis
-No furlough
-Test and furlough if becomes symptomatic 4-21 days after exposure
Special cases:
-If exposed, asymptomatic and prophylaxis is declined, mask starting 5 days after first possible date of exposure until 21 days after last possible date. Re-offer meds, test and furlough if symptoms develop.
- If exposed, symptomatic, and treatment declined: furlough for 21 days AFTER ONSET OF COUGH paroxysms. Consider testing.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Special cases:
-If exposed, asymptomatic and prophylaxis is declined, mask starting 5 days after first possible date of exposure until 21 days after last possible date. Re-offer meds, test and furlough if symptoms develop.
- If exposed, symptomatic, and treatment declined: furlough for 21 days AFTER ONSET OF COUGH paroxysms. Consider testing.

2.5

JWCH INSTITUTE, INC. Health & Medical Services

RECUPERATIVE CARE PROGRAM
Communicable Disease Disclosure

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

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

DISEASE BEING REPORTED:

S2: C-6
Click here to return to Standards Page

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
☐ Needle or blood exposure
☐ Child care
☐ Food / drink
☐ Recreational water exposure
☐ Foreign travel
☐ Sexual activity
☐ Household exposure
☐ 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-gonoccoccal 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.

Policy#: 0103	JWCH Institute, Inc. Policies & Procedures	Approved By: Dr. P. Gregerson, CMO A. Ballesteros, CEO
Policy Title: Disposition of Patients with Contagious Diseases.	JWCH INSTITUTE, INC. Health & Medical Services	**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.

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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)

- 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

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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

THE NATIONAL EXECUTIVE HOUSEKEEPERS ASSOCIATION, INC.

CERTIFICATE of COMPLETION

JOSE MORALES, C.E.H.

HAS SUCCESSFULLY COMPLETED A 0.2 HOUR CONTINUING EDUCATION

PROGRAM COURSE IN "PEST CONTROL MANAGEMENT"
(TITLE)

SPONSORED BY CHICAGO CHAPTER OF N.E.H.A.

Course # 950111A

CEU Awarded 0.2

JANUARY 11, 1995
(DATE OF COURSE)

The Continuing Education Unit

(NATIONAL PRESIDENT)

(PROGRAM EDUCATION COORDINATOR)

Form ED 24-87

THE INTERNATIONAL EXECUTIVE HOUSEKEEPERS ASSOCIATION, INC.

Certificate of Completion

Jose Morales, CEH

Has Successfully Completed A 2.0 Hour Continuing Education

Program Course In How to inspect for Rodents

Sponsored By I.E.H.A. Chicago Chapter

Course #990942D CEU Awarded 0.2 10/13/99
(Date of Course)

E. Susann Commens
(Association President)

INTERNATIONAL EXECUTIVE

THE INTERNATIONAL EXECUTIVE HOUSEKEEPERS ASSOCIATION, INC.

Certificate of Completion

JOSE MORALES

Has Successfully Completed A 2 Hour Continuing Education

Program Course In How To Select A Pest Control Company

Sponsored By IEHA Chicago Chapter

Course # 980909 CEU Awarded .2 9|9|98 (Date of Course)

E. Suzanne Commens
(Association President)

Charles J. Johnson, REH
(Program Education Coordinator)

INTERNATIONAL EXECUTIVE HOUSEKEEPERS ASSOCIATION, INC.

THE INTERNATIONAL EXECUTIVE HOUSEKEEPERS ASSOCIATION, INC.

Certificate of Completion

Jose Morales

Has Successfully Completed A 2.0 Hour Continuing Education

Program Course In Bird Elimination

Sponsored By IEHA Chicago Chapter

Course # 010110A CEU Awarded .2 1/10/01 (Date of Course)

Jane Woodland
(Association President)

Charles J. Johnson, REH
(Program Education Coordinator)

INTERNATIONAL EXECUTIVE HOUSEKEEPERS ASSOCIATION, INC.

Housekeeping

The work site is maintained in a clean and sanitary condition according to a written schedule for cleaning and methods of decontamination. The schedule is based upon the location within the facility, type of surface to be cleaned, type of soil present, and tasks or procedures being performed in the area.

All equipment and working surfaces are to be cleaned and decontaminated after contact with blood or other potentially infectious materials. Contaminated work surfaces are to be decontaminated with an appropriate disinfectant after completion of procedures, immediately or as soon as feasible when surfaces are overtly contaminated or after any spill of blood or other potentially infectious materials and at the end of the work day.

Protective coverings (plastic wrap, surface protectors, aluminum foil, etc.) used to cover equipment and surfaces are to be removed and replaced as soon as feasible when they become contaminated.

All reusable bins, pails, cans and similar receptacles which have a reasonable likelihood for becoming contaminated with blood or other potentially infectious materials are to be inspected and decontaminated on a regular basis and cleaned and decontaminated immediately or as soon as feasible upon visible contamination.

A Spill Kit (See Appendix F and Appendix G) is made available for cleaning up spills of blood and OPIM safely. Broken glassware will not be picked up directly with the hands. Mechanical means, such as tongs, forceps, or a dustpan will be utilized.

Contaminated reusable sharps and instruments are placed immediately, or as soon as feasible, in covered, puncture-resistant, leak proof, labeled containers. These containers are accessible to personnel and located as close as is feasible to the immediate area where sharps are used. Containers will not be allowed to overfill. Containers are replaced when they are 2/3 full.

Regulated waste is to be placed in covered leak proof, labeled containers that are closed prior to removal. If outside contamination of the container occurs, it is placed in a second container which is also leak-proof, labeled and closed prior to removal. Specify locations of infectious waste containers.

When moving containers of contaminated sharps from the area of use, the containers will be closed prior to removal and placed in a secondary container if leakage is possible. The secondary container will be covered, labeled and constructed to contain all contents and prevent leakage during handling, storage, transport or shipping.

Disposal of all regulated waste is in accordance with federal, state, and local regulations.

Contaminated laundry (e.g., lab coats) is handled as little as possible and with minimum of agitation. Wet contaminated laundry is to be bagged or placed in a leak proof, labeled, container at the location where it was used and will not be sorted or rinsed in the location of use. Employees who have contact with contaminated laundry will wear gloves and other appropriate PPE.

Excerpted from Infection Control Manual

Bed Bugs:

Interfaith House has adopted this Integrated Pest Management Plan to outline procedures to be followed to protect the health and safety of staff, residents, and visitors from pest and pesticide hazards.

To aid in combating bed bugs the following procedure should be used:

1. All clothing for new intakes should be washed and dried prior to being. placed in a room, all new Intakes should shower and place all clothing in a plastic bag marked with their room and bed number, they will be given a clean set of clothing from our clothing room to put on.

If a bed Bug is spotted the following procedures will be followed.

a. Using a flashlight do a visual inspection of the area identified as possible having bed bugs. Search seams, cracks, and adjacent items. Do not move anything in or out of the room until it can be inspected by your contract pest management company.
b. Contact the contract pest management company for positive identification of bed bugs. If the contract pest management company finds no bed bug evidence, evaluate the original complaint. Did the resident bring a bed bug to the front desk, or did they complain about bites? Use the evidence presented by the guest to decide if the room should be treated or not. Record the complaint, the result of the inspection, and your treatment decision.
c. If bed bugs evidence is found by your pest management, a thorough inspection of the room is required to determine where bed bugs are harboring.
d. Any paintings or items on the walls should be removed from the wall for inspection and treatment.
e. The entire bed area must be inspected, including frame and any surrounding items.
f. If the bed is going to remain in the room, the mattress and frame must be treated (see the fact sheets regarding chemical and non-chemical treatment methods), if the mattress is cloth it must be sealed in a high quality mattress encasement.
g. If the mattress, or other infested furniture are to be disposed of, the furniture needs to lightly treated with insecticide on the exterior surfaces, and bagged before being transported out of the room. This is so that no bed bugs fall off the furniture infesting the hall or elevator.
h. After all unwanted furniture is disposed of, the pest management professionals will inspect and treat all of the remaining furniture, lockers, baseboards, electrical outlets, crack and crevices using a combination of non-chemical methods and/or insecticides labeled for those locations.
i. All discarded furniture left outside the facility should be slashed, marked, or in some way damaged to keep people from removing it from the trash heap and taking it home.

   The treated room should be inspected again after 48 hours to determine if there are any surviving bed bugs. If live bed bugs are found, they should be treated and the room should be inspected again at 72 hours.
j. The room should also be inspected and treated again after 14 days and 28 days, so that any remaining eggs have had time to hatch.

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: _____

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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 *Formulation 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 ft²)

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:

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.

3.1 Resident Life Services – Intake

3.11 Bed Reservations

Policy: Interfaith House reserves beds only after the person has been cleared for discharge from the hospital and the Intake Coordinator, Central Desk Staff (if referred by DFSS), or another staff has stated that they are appropriate for the program; at the time that that are

Procedure:

1. Reservations are made by DFSS through Central Desk for the Assessment Program and by hospital staff through the Intake Coordinator for the Respite Program.
2. The Intake coordinator or Central Desk personnel determine whether a bed is available based on the specified number of beds occupied in each program. If a bed is available and the candidate fits the Interfaith House requirements, a bed is reserved by writing the name on the board at Central Desk.
3. If the new resident does not show up within the respective time limit, the Intake Coordinator, Program Director or the RCA Manager will erase the name from the board and the bed is no longer reserved. Exceptions may be made by a Manager.

_____ _____

Jennifer Nelson-Seals Date

WHO SHOULD COME TO INTERFAITH HOUSE?

53 F2

- Unattached men and women who are homeless and being discharged from the hospital needing a short term placement (four to six weeks) in order to complete their recovery from a physical illness or injury. **Interfaith House is not appropriate for patients requiring long term nursing home care.**
- Patients who can physically care for themselves (e.g. dress, bathe, self-ambulate, attend personal hygiene and take medication as prescribed), who no longer require bedside nursing care, can come to the dining room for meals, make their bed, and keep their living space neat. Interfaith House provides support to residents to complete their healing *but it is not a medical treatment facility.*
- Patients who are mentally stable. *Interfaith House is not a psychiatric treatment facility.*
- Patients who understand their care plan and can carry out the measures necessary to implement them with the help of Interfaith House staff, including compliance with medications and returning to their physicians for follow-up care.
- Patients who are able to live in a communal environment, share a bedroom with four or five roommates, share meals in a common dining room with 64 residents, participate in educational sessions and group meetings (including AA and NA if appropriate) and follow Interfaith House conditions of residency.
- Patients who will not use drugs or alcohol during their stay at Interfaith House.

**In order to provide the best possible service to residents, it is vital that all medical conditions and mental health history be shared with the Intake Administrator.*

SERVICES PROVIDED

ONE-TO-ONE CASE MANAGEMENT – Upon admission, each resident is assigned a case manager who offers guidance in obtaining financial assistance, housing opportunities, employment or employment training, and educational opportunities.

HEALTH SERVICES – Nearly 70 percent of our residents have no relationship to a primary care physician or ongoing health services when they arrive. To respond to this need we worked with Rush University College of Nursing, Heartland Health Outreach, and P.C.C. Community Wellness Center to open our Health Services Collaborative, offering a variety of vitally important health services in an on-site clinic staffed by physicians and nurse practitioners from partnering institutions. In addition, we offer transportation for follow-up medical visits if the resident is unable to self-transport and, residents are provided a safe place to store their medications.

BEHAVIORAL HEALTH – On-site Mental Health Case Managers assess incoming residents and make appropriate referrals to mental health services. Interfaith House offers substance abuse assessment, one-to-one support and additional programming to serve our clients who struggle with substance abuse.

HIV/AIDS – Interfaith House partners with local HIV/AIDS outreach services to provide confidential on-site testing and counseling; access to primary care, psychosocial support programs, and medications; supportive housing referrals; and weekly HIV/AIDS/STD education programs.

Making a Referral to Interfaith House

Please complete our Respite Intake Form and **fax** it to the Intake Administrator at **773.533.9034**. Follow-up calls to our Intake Administrator should be made at **773-533-6013 ext.255**. Intake hours are **Monday through Friday** between the hours of **9:00 a.m. and 4:00 p.m.** Referrals after business hours must be made through the **Chicago Department of Human Services.**

Interfaith House is an ADA accessible residential facility accepting homeless adults who need time and a safe, clean place to complete their recovery from an acute medical condition, although referrals who have an acute medical condition with a secondary mental illness or substance abuse history may be accepted.

RESIDENTS REFERRED TO INTERFAITH HOUSE MUST BE:

- Mentally alert and psychiatrically stable
- Able to participate in their own medical care plan
- Able to manage basic living skills without assistance
- Expected to recover in 30 days or less
- Living with an acute medical illness or injury
- Provided a 30 day supply of medications/medical supplies

REFERRING MEDICAL FACILITIES MUST:

- Transport each referral with 30 day supply of medication to Interfaith House by 3:00 p.m.
- Identify a primary care physician who will prepare and be responsible for the referral's comprehensive medical recovery plan.
- Obtain informed consent from the referral for all aspects of such medical care plan prior to transfer to Interfaith House.

Please fax to (773) 533-9034

1/11

2

interfaithHOUSE
Restoring health, rebuilding lives, returning home.

REFERRAL APPLICATION

Client name:_____ Date of birth: ____/____/_____

SSN: _____ Gender: ___Male ___Female ___Transgender

Preferred language: ___English ___Spanish ___Polish ___Other:_____

Race ethnicity: ___African-American ___Hispanic-White ___Hispanic-Black ___Caucasian
___Native-American ___Asian/Pacific Islander ___Other:_____

Referring institution/physician:_____
Name Phone/Pager # Fax#

Referring social worker:_____
Name Phone/Pager# Fax#

Client's last permanent address: _____

Zipcode: _____

Emergency contact person: _____ Relationship:_____

Address:_____ Phone: _____

Please check the situation that most accurately defines the client's living situation prior to hospitalization. All referrals must be homeless as defined by HUD:

___ Living on the street
___ Emergency Shelter
___ Transitional Housing
___ Evicted: formal proceeding
___ Evicted: by family/friend
___ Evicted: informal
___ Institution: less than 31 days
___ Institution: greater than 31 days
___ Domestic Violence

Is this the clients first time being homeless? _____ Number of times homeless? _____

Does the client have an income? _____ Source of Income: _____

Contact information for prior living situation:_____
If different from permanent address and/or emergency contact

Address:_____ Phone: _____

Date of hospital admission: ____/____/_____ through _____
Estimated date of discharge

Please describe the client's current mental status (e.g. confused, alert, disoriented, tearful, etc.):

_____

Does the patient have a psychiatric history? ___No ___Yes: Date of diagnosis_____

If yes, what is the diagnosis? Axis I _____ Axis II_____

If no, does the client currently present any of the following:

Cognitive impairment (e.g. memory, judgment)	___Yes	___No
Though disorder	___Yes	___No
Dementia	___Yes	___No
Paranoia	___Yes	___No
Confusion	___Yes	___No

Please fax to (773) 533-9034

Acute/Principle illness or injury:_____

Other medical conditions:_____

Estimated time needed at Interfaith House to stabilize medical conditions:_____

Dietary needs (check all that apply):

General ____
Diabetic ____
Low cholesterol ____
Low Salt ____
Lactose intolerant ____
Liquid ____
Calorie_____
Other_____

Disabilities (check all that apply):

Hypertension ____
HIV/AIDS ____
Seizure disorder ____
Diabetes ____
Alcohol abuse ____ Last used:_____
Drug abuse ____ Last used:_____
Substance(s) used:_____
_____

Medications & supplies that will be needed by client at time of discharge & reason for need *(please note that we are a drug-free environment. If pain medications are needed, if possible, please consider non-narcotic based options).*

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Is the client taking Methadone? Yes No If yes, what dose and for what reason?

_____

Upcoming medical/psychiatric follow-up appointments (Location/Date/Time/Phone Number):

1. _____
2. _____
3. _____

Type of insurance: ___None ___Medicaid ___Medicare A/B ___Veterans Administration ___HMO/Private ___ Other_____

Is client able to manage the following basic living skills **without assistance**:

Showering/hygiene	___ Yes ___ No	Take medication as prescribed	___ Yes ___ No
Dressing his/herself	___ Yes ___ No	Change medical dressings	___ Yes ___ No
Manage bowel/bladder	___ Yes ___ No	Manage all other medical supplies	___ Yes ___ No

If no to any of the above, how will the client need assistance?_____

_____

Has the Interfaith House program been discussed with the client, is he/she interested and willing to be referred to our program, and has informed consent been obtained? ___Yes ___No

Please fax to (773) 533-9034

INTERFAITH HOUSE REFERRAL
REFERRAL CHECKLIST

Interfaith House is a residential facility accepting homeless adults who need time and a safe, clean place of respite to complete their recovery from a medical condition under the care of their referring institution. Interfaith House is not a medical, psychiatric, or substance abuse treatment center, but serves as a place where individuals can safely recuperate and access other needed services. Please use this checklist to help guide you though our referral process. We cannot accept a referral until all of these items have been completed. Thank you.

Intake Administrator: **James Nelson**
Intake Hours: 9:00 AM – 4:00 PM Monday through Thursday; 9:00 AM – 3:00 PM on Friday
Intake Phone Number: (773) 533-6013, extension 231 Intake Fax Number: (773) 533-9034

____ Fax in the completed Referral Application Form (at this point the client will be added to the wait list, pending completion of the referral process and approval of the client)

____ Fax in the completed Tuberculosis Test Verification Form

____ Fax in the completed Signed Medical Diagnosis Form, this form should be completed by a physician whether or not the individual has HIV/AIDS

____Fax in the completed Homelessness Verification Form

____ Discuss the Interfaith House program and our conditions of residency with the client, which briefly include: following their medical recovery plan, abstaining from alcohol and illegal drugs, participating in all house activities and programs, and respecting fellow clients, staff, the facility, rules and procedures. Residents will be living in a diverse, community setting and are expected to be able to share general living spaces, including bedrooms and bathrooms.

____ Arrange for a time in which our Intake Administrator can speak with the client by phone

____ Arrange for the client to arrive at Interfaith House with a 30-day supply of all needed medications and medical supplies. (unfilled prescriptions **do not** meet this requirement)

____ Arrange for Home Health Care if the client will need assistance with any basic living skills (please refer to basic living skills that are listed on the Referral Application Form)

____ Arrange for needed follow-up medical and psychiatric appointments

____ Arrange for transportation to Interfaith House upon acceptance of referral

The items listed below are helpful to us when working with new clients. If applicable, please fax us copies of the following:

Psychiatric assessments, Recent toxicology results, Medical insurance cards, Proof of income
Any other medical records as requested by our Intake Administrator

Once our Intake Administrator confirms that all of the above items have been completed and the client is appropriate for our program, you will be notified when a bed becomes available.

outline Referral & admission system
S3: C-2,4

S3: C-2,4
Click here to return to Standards Page

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

S3: C-4

- 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

S3: C-4

- 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

Example 1

Pt. 3 Criteria 1: a, b, C, d

Referral System

Intake – Criteria for Admission

Policy

Interfaith House screens prospective residents so that only those who can benefit from the services are admitted. This process assures that those whose needs can be met more effectively elsewhere will not occupy a bed at Interfaith House. Any referral deemed appropriate after the screening process will be reserved a bed, provided that one is available, if a bed is not available at that time Interfaith House will provide the caller with an estimation of when a bed will be. Referrals should be taken only from hospitals, DFSS, or key partners. Screening is done by Central Desk staff for CDHS referrals; the Intake Administrator will provide a screening for all other referral sources with the consultation of medical staff if needed.

Procedure

1. The caller is asked whether the candidate meets the criteria for admission.
   - Unattached men and women who are homeless and being discharged from the hospital needing a short term placement (four to six weeks) in order to complete their recovery from a physical illness or injury. **Interfaith House is not appropriate for patients requiring long term nursing home care.**
   - Patients who can physically care for themselves (e.g. dress, bathe, self-ambulate, attend personal hygiene and take medication as prescribed), who no longer require bedside nursing care, can come to the dining room for meals, make their bed, and keep their living space neat. Interfaith House provides support to residents to complete their healing *but it is not a medical treatment facility.*
   - Patients who are mentally stable. *Interfaith House is not a psychiatric treatment facility.*
   - Patients who understand their care plan and can carry out the measures necessary to implement them with the help of Interfaith House staff, including compliance with medications and returning to their physicians for follow-up care.
   - Patients who are able to live in a communal environment, share a bedroom with four or five roommates, share meals in a common dining room with 64 residents, participate in educational sessions and group meetings (including AA and NA if appropriate) and follow Interfaith House conditions of residency.
2. If the candidate is medically appropriate for residency at Interfaith House, the Central Desk staff member or a member of the Health Services Department fills out the appropriate *Intake **Questionnaire.***
3. During the screening process, the staff member conducting the intake will speak to the potential candidate as well as the referring personnel. Staff should complete the appropriate pages with the worker from the referring institution the remaining pages with the candidate.
4. Staff will verify with referring provider that candidate has homelessness documentation and documentation of physical disability if applicable
5. If the candidate is approved based on the Screening Process, he/she is approved for admission to Interfaith House. A bed is reserved for the candidate for the next 12 or 24 hours depending on the referral source.

E4

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

MEDICAL GUIDELINES FOR INTERFAITH HOUSE INTAKES

Please use the questions for the admitting diagnosis to determine whether an individual is appropriate for Interfaith House. These questions and information are meant as a guideline only. When in doubt, speak with health services before admitting the resident.

Ideally, all residents should come with a 30-day supply of medication. If there is a situation in which someone is requesting to admit an individual without medications, please use the following coding system to determine whether this is possible or not:

1 – Must have medications and supplies with them on arrival – NO EXCEPTIONS
2 – Could wait until next business day for medications
3 – Individual can come to IH, but must go to medical provider the same day for medications
4 – Requires consult with health services or behavioral health services
N/A – Not applicable for that specific diagnosis; check for issues with any secondary diagnoses

Asthma (4)

- There should be an infection in the lungs OR
- There needs to be new meds or antibiotics

Cancer & Chemotherapy (4)

- Is individual newly diagnosed? Is individual in need of new treatment? *Should be yes and beginning in 30 days*
- How long has the individual had the diagnosis and what treatment have they received? *Should be recent diagnosis or recent recurrence*
- Have they been having diarrhea? *If yes, there should be a plan for treatment*
- Is this person receiving treatment for cancer? *Should be yes*

Diabetes (1)

- What have the last 2 blood sugars been and when were they taken? *Should be within the last week and be above 150 or below 100*
- Is individual newly diagnosed or has individual just recently changed meds? *Should be yes*
- Does individual know how to administer own meds? *Should be yes*
- Does individual know what kind of food and beverages he/she should have and not have? *Make a note, if no*
- Does individual have his/her own glucometer? *If no, ask if hospital can provide one*

- *Blood sugar should be tested on arrival; if above 250 or below 60, individual should go to a medical provider for treatment prior to intake completion*

Dialysis/Kidney Failure (4)

- Can individual produce urine? *Should be yes*
- Does individual have a catheter and all necessary supplies? If yes, can individual self-care with it? *Should be yes to both*

Frostbite/Infection (1)

- Can individual do own wound care? If not, has home health care been pre-arranged? *Should be yes to 1st or 2nd question*

Heart Disease (4)

- Has individual fallen, felt dizzy, or had chest pains in the last week? *Make note of answer*
- Is individual able to take stairs? *Make note of answer*
- What medications is individual taking? Have there been any recent changes in medications? (If individual is taking Nitroglycerin, how often has he/she used it in the last 2 days) *Make note of answer*

Hepatitis (A, B, C) (2)

- What treatment or follow-up has been arranged? *Should be medications or follow-up appointment*
- Is the individual taking interferon? *Make note of answer*
- How long has the individual been diagnosed with this condition? *Should be a recent diagnosis (within 1 month) or recently started new treatment plan*
- Is the individual oriented to his/her surroundings? *Should be yes*

HIV/AIDS (2)

- Does individual have a doctor's statement confirming status? *Must be confirmed*
- Does individual have meds with him/her? *Does not have to have medication with them*
- Does individual have information from most recent medical appointment? *If yes, please have individual present this to staff upon arrival so we may obtain some medical history. Not necessary for admission.*
- Are they end-stage? *If so, resident must be able to self care.*
- Are there any secondary infections? *Make note of answer*

Hypertension/High Blood Pressure (1)

- What has individual's blood pressure been in the last day? *Should be in the range listed below*

- Has individual recently started on hypertension/high blood pressure medication? *Should be yes.*
- Blood pressures that would qualify for admission to IH: HIGH = ≥150
  LOW = ≤100

>90 <60

Infection (1)

- Does individual have the medications required (antibiotics, etc.)? *Should be yes, prior to admission.*
- Does individual require wound care? Is individual able to do own wound care? If not, has a home health care worker been assigned to him/her? *The individual should be able provide own care or have home health care previously arranged.*

Neuropathy (2)

- Does individual know why they have neuropathy? (There's usually another illness that has caused it.) *Not required for admission.*
- Does individual require ambulatory aides? *If yes, they should have the aide prior to arrival.*
- What is the individual's plan for pain management? *Resident should come with needed medications.*

Pregnancy (1, 4)

- Has individual had complications during the pregnancy? *Should be some special condition.*
- How far along in the pregnancy is the individual? *Make note of answer*
- Has individual received, or is individual receiving now, pre-natal care? *Not required for admission.*
- Is individual taking any meds now or did individual have to stop meds during this pregnancy? *If psych meds are involved, please consult Behavioral Health Services Manager*
- Has the individual been doing drugs or smoking while pregnant? *Document response*
- Individual MUST be approved by Health Services

Seizure Disorder/Epilepsy (1)

- When were the last 2 seizures individual experienced? *Should be within the last 2 weeks*
- Was individual hospitalized for the last 2 seizures? *Document information*
- Does individual have enough medication for the next week? *If no, individual must first go to medical provider for medication*

- Has individual recently started on hypertension/high blood pressure medication? *Should be yes.*
- Blood pressures that would qualify for admission to IH: HIGH = ≥150
  LOW = ≤100

>90 <60

Infection (1)

- Does individual have the medications required (antibiotics, etc.)? *Should be yes, prior to admission.*
- Does individual require wound care? Is individual able to do own wound care? If not, has a home health care worker been assigned to him/her? *The individual should be able provide own care or have home health care previously arranged.*

Neuropathy (2)

- Does individual know why they have neuropathy? (There's usually another illness that has caused it.) *Not required for admission.*
- Does individual require ambulatory aides? *If yes, they should have the aide prior to arrival.*
- What is the individual's plan for pain management? *Resident should come with needed medications.*

Pregnancy (1, 4)

- Has individual had complications during the pregnancy? *Should be some special condition.*
- How far along in the pregnancy is the individual? *Make note of answer*
- Has individual received, or is individual receiving now, pre-natal care? *Not required for admission.*
- Is individual taking any meds now or did individual have to stop meds during this pregnancy? *If psych meds are involved, please consult Behavioral Health Services Manager*
- Has the individual been doing drugs or smoking while pregnant? *Document response*
- Individual MUST be approved by Health Services

Seizure Disorder/Epilepsy (1)

- When were the last 2 seizures individual experienced? *Should be within the last 2 weeks*
- Was individual hospitalized for the last 2 seizures? *Document information*
- Does individual have enough medication for the next week? *If no, individual must first go to medical provider for medication*

Stomach Ulcers (2)

- What is individual's treatment plan? *Should have new meds, surgery, or follow-up appointments*

Trauma (1)

- When was individual injured? *Should be within the last 2 weeks, individual has cast, external fixator, or individual is being referred by hospital*
- What kind of injury was it? *Document response*
- How does the individual move around? (Wheelchair, crutches, cane, etc.) *If individual requires walking aides, he/she must have them upon admission*
- Can individual self-care? (Shower, bathroom, dress, eat, etc.) *If no, make referral to ICF.*
- What is individual's plan for pain management? *Should have medication or directions for over the counter meds*

Active Tuberculosis (1)

- Has the individual been diagnosed and treated for active TB in the last 30 days? *Should be yes*
- Does the individual have his/her TB medications? *Should be yes*
- Does the individual have documentation of 3 negative sputums, on 3 separate days? *Should be yes*

GENERAL QUESTIONS TO ASK ALL INTAKES

- Does individual have follow-up appointments
- Does individual have 30-day supply of medications and any needed supplies? Prescriptions are not considered a valid supply of medications.
- Individual must have an acute, short-term illness or injury
- Will the individual be able to stabilize medically in roughly 30 days? (Unless HIV is the admitting diagnosis)
- If individual requires an ambulatory aide, it must be with him/her upon admission.
- If individual is working, why do they require respite care?
- Does individual know the date? Day? Time? Where they are?
- Does individual understand his/her medication schedule?

GUIDE FOR SECONDARY DIAGNOSES

Blindness (N/A)

- If individual has meds of any sort, must be able to self-administer & must have necessary equipment to do so

Deafness (N/A)

- Does individual have follow-up services? *Not required for admission*
- How does the individual communicate? *Needs to be able to communicate clearly and effectively*

Developmental Disability (N/A)

- Individual must know how and when to take medications
- Individual must have capacity to live and participate in community with 63 other residents

Elderly (70 years or older) (N/A)

- Can individual self-care? *Should be yes*
- Is the individual continent? *If not, resident should have supplies for this condition*

Psychiatric History (must be in addition to having a medical diagnosis) (1, 4) *This should only be a secondary diagnosis*

- Is individual currently experiencing symptoms of depression? Is individual seeing or hearing things? *Document response*
- If taking medications, who is the individual's psychiatrist? *Document response*
- Does individual know the date? Time? Where he/she is? *Should be oriented to time and place*
- Has individual ever been admitted to a hospital for psychiatric reasons? *If yes, document all applicable information below. Previous hospitalization is not required nor does it prohibit admission to Interfaith.*
    - Which hospital?
    - When (month/year)?
    - Why? (What happened?)
    - What was the diagnosis given?
- Does the individual have any feelings of harming self or others? *If yes, consult with Behavioral Health Services (or on-call staff, if behavioral health is not available) to determine treatment plans prior to admission to IH.*

- Is individual currently linked with a Community Mental Health Center? *Document information*

Tuberculosis – (non-active or latent)

- Has the individual had a TB test in the last 30 days (either PPD or chest x-ray)? Do they have written documentation of the test results? *Document response. Ideally, individual should have had the test (and documentation) within the last 30 days, but it is not necessary. If they had a positive PPD test within the past 30 days, we would*

need chest x-ray results and information regarding whether or not medications were prescribed.

- Has the individual ever had a positive PPD test? *If yes, ask when they had their last chest x-ray and document response*
- Does the individual have any symptoms of active TB (productive cough, fever, etc.) that are otherwise unexplained? *If yes, consult with Health Services*
- Has the individual been diagnosed with active TB within the last 30 days? *If yes, the questions for Active Tuberculosis should be asked*

HOMELESS AND DOMESTIC VIOLENCE PROGRAMS
NO IDENTIFICATION/ NO INCOME/
SUBSTANTIAL LOSS OF INCOME
AFFIDAVIT

Agency Name: Interfaith House **Date:** _____

Client Name: _____ **Address: 3456 W Franklin Blvd, Chicago, IL 60624**

(Photocopy client's ID, or, if the client does not have a state ID of Social Security Card, please complete the portion below)

I hereby certify that I have no identification.

Client Signature: _____ **Witness:** _____
(Agency Representative)

(check the appropriate box)

☐ **Client was provided assistance and/or referral to initiate the establishment of a State ID, Driver's License, and Social Security Card.**

☐ **Client declined assistance in initiating the process of obtaining a State ID, Driver's License, Social Security Card.**

(The below should be completed for clients without an income, no proof or income, or those that suffered a substantial loss of income).

I hereby certify,

(check the appropriate box)

☐ I have no income ☐ I have no proof of income ☐ I have suffered a substantial loss of income

Indicate cause for substantial loss: _____
_____
_____

Income Source: _____ **Amount:** _____ **Termination Date:** _____

Client Signature: _____ **Witness:** _____
(Agency Representative)

(Note: This form must be completed at the time of intake, and maintained in the client file.)

Revised March 2014

Please remember to complete/provide the following:

- Complete ALL fields
- Provide current TB results (no more than 30 days old).
    - If tested (+) positive for TB in the past, then you may provide a chest x-ray, no more than a year old.
- Provide current psychiatric notes if there is a psych history
- Client must bring a 30 day supply of medication.
- Provide client contact information for client intake interview

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
9				
10				
11				

S3: C-12,13,14
Click here to return to Standards Page

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:

S3: C-11,14

1) S3: C 14, Click here for complete appt record
2)
3)

S3: C-12,13,14

Click here to return to Standards Page

Past Medical History	**Current Medications & Dose:**
	S3: C-12, click here to see hospital discharge med list
Vaccinations:	**Family Hx:**

Disease	Relative/comments	
	Mom	
	Dad	
	Siblings	

Past Surgical History:	**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	**INITIAL ORDERS:** ☐ PPD ☐ Dtap ☐ CXR ☐ EKG
	OTHER:
1) Admit to Recup Care	
2) Hospital discharge instructions and f/u care discussed with pt	Wound Care ☐ Wet to dry ☐ Dry dressing — Frequency:
3) Medication reconciled and discussed with patient	**Tx Area:**
S3: C-12	L ☐ Today ☐ Schedule:
	L ☐ Initial (CMP, ALT, CBC, RPR) ☐ Lipid profile
Pt expresses verbal understanding and is able AND willing to follow instructions:	A ☐ HbA1C ☐ PSA ☐ UA ☐ µ Al/Cr
☐ Yes ☐ No S3: C-13, click here to return to Standards pg	B Other Labs:
	Ref hops ELOS: wks — Recup ELOS: wks
RTC 1 wk	**Next MD/PA Appt:**
PROVIDER SIGNATURE: **DATE:**	☐ Dennis Bleakley, MD ☐ Lucien Alexandre, MD ☐ Thanh Chu, PA-C ☐ Other:

interfaithHOUSE
Restoring health, rebuilding lives, returning home.

HOMELESSNESS VERIFICATION

TO BE COMPLETED BY APPLICANT

Please check the statement which applies to your current housing situation and complete the *Applicant Certification* below. Service provider's that can verify your homelessness situation must complete the bottom portion of this form.

- ☐ I am without housing and live on the streets, in a car, non-residential building, etc.
- ☐ I am without housing and spend nights in a shelter, institution, or temporary housing.
- ☐ I am staying with another family (for < 30 days) and there are not enough beds for everyone.
- ☐ I am at risk of losing housing due to eviction, sale of housing, loss of income, or other crisis. (Documentation of Eviction is required – 14 days or less)
- ☐ I am fleeing a domestic violence situation

APPLICANT CERTIFICATION

I hereby certify that the information I am providing is true and accurate. I lack the resources and support networks needed to obtain housing.

Printed Name of Head of Household	Signature of Head of Household	Date

TO BE COMPLETED BY SERVICE PROVIDER

HOMELESSNESS STATUS VERIFICATION

I CERTIFY THAT _____ (applicant) IS HOMELESS.

- ☐ The applicant is staying in a place not meant for human habitation (parks, sidewalk, etc.)
- ☐ The applicant is staying in a shelter (Emergency, Transitional, Supportive)
  Name of Shelter: _____
- ☐ The applicant is staying a short time 30 days or less in a hospital or institution.
- ☐ The applicant lives with another family which does not have sufficient beds for everyone
- ☐ The applicant is being discharged from an institution, (Mental Health, Substance abuse or Jail/Prison) where he/she has resided for more than 30 consecutive days.
- ☐ The applicant is fleeing a domestic violence situation

Printed Name of Service Provider	Signature of Service Provider	Professional Title
Organization	Phone Number	Date

Please fax to (773) 533-9034

JWCH INSTITUTE, INC.
Healthy & 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)	☐	☐

S3: C-11

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

Specialty	Date	Time	RM #	Contact #

S3: C-11
Click here to view FULL follow-up appt record

Form Completed By: _____
Signature

Referral form

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 _____ (Checked By) Red Dot: ☐ Y ☐ N

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

Reviewed by: _____ (Provider Signature) _____

Referral forms

Patient Name _____ DOB_____

Yakima Neighborhood Health Services
12 South 8th St, PO Box 2605
Yakima WA 98907-2605
www.ynhs.org

Hospital or Medical Provider – Referral of Homeless Person for Respite Housing:

1. Contact YNHS Outreach at (509)249-6232 (Monday – Friday) to identify if housing shelter is available (before completing this form).
2. Fax this Referral Form + Hospital Discharge patient instructions including H/P to Yakima Neighborhood Health 107 house at (509)249-2800.

Referring Medical Provider

Provider Name:	**Soc.Serv Pager/Phone:**
Hospital or Clinic:	**Service:**

Is YNHS the PCP ? ___Yes If not, who is / will be _____

Referring Medical Provider to Complete all Following Sections

Respite Criteria – Check Boxes Below (must meet all criteria)

Homeless or in Emergency / Transitional Housing		Willing to see respite staff daily and can comply independently with medical recommendations from medical provider	
Acute medical problem that would benefit from short-term respite		Behaviorally appropriate to be left alone (including no known suicidal or assaultive risks)	
Independent in ADL's including medication administration		No intravascular lines	
Independent in mobility		Does not require > 4 week respite stay	
Continent of urine and feces		Does not need SNF placement	
Medically stable		Patient understands respite facility is alcohol and drug free	
Has not received benzodiazepines for alcohol withdrawal in past 24 hours			

Diagnosis requiring respite:_____ _____Anticipated Stay Needed _____ Days

 # Days patient was hospitalized _____ W/O Respite, Days longer you would keep Patient _____

Last Vital Signs: T max_____ BP_____ HR_____ RR_____ RA O2 Sat___

ETOH:	**Yes**	**No**	**Extremity**	**Wt. Bearing**	
Hx ETOH SZ:	**Yes**	**No**	**RLE**	**FULL**	
Hx DT's:	**Yes**	**No**	**LLE**	**WBAT**	**Allergies_____**
Drugs	**Yes**	**No**	**RUE**	**TTWB**	**Diet _____**
			LUE	**NWB**	**Psych Dx_____**
					Psych F/U_____

Special monitoring, activity restrictions (if not on Discharge Instruction Forms):

_____

- Attach Current or Discharge Medication List , H& P, and Hospital Facesheet.

Medical Provider Signature:_____ Date:_____

Clinical Summary

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CONFIDENTIAL MORBIDITY REPORT

Public Health

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

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)

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3 cont. DIAGNOSIS & TREATMENT

ADULT SYPHILIS

☐ **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 ☐

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**

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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	LACUSC	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	LACUSC	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, Jesler	HUCLA	Melissa Barcelos			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 sw pt was dc sober living.
Doe, Hamid	LACUSC	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 merged 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	Claula Curcy			7/15/13	3:18 PM	7/15/13	3:49 PM	9,10,16	Pending													
Doe, Louis	RLA	Cesear 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	LACUSC	Eddie Klein			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	LACUSC	Amy McCormick			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 Barcelos			7/17/13	10:50 AM	7/17/13	11:13 AM	10,16	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 referesl, pt was denied.
Doe, Joseph	LACUSC	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	LACUSC	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

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	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	NO	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, Rafael	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	7/29/13	2:00 PM	N/A	N/A	N/A	7/29/13 pt decided to stay with family.
	Doec, mark Anthony	HUCLA	Hesmik			7/25/13	2:45 PM	7/25/13	4:01 PM	9,10,15	Pending													
	Doe, John	LAC/USC	Marisa Orozco Tapia			7/26/13	9:30 AM	7/29/13	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	Finers			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	7/25/13	3:50 PM	N/A	N/A	N/A	
	Doe, Brandon	LAC/USC	Carin Stinson			7/26/13	3:02 PM	7/29/13	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	3/25/13	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 Bella			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 Johnsonco	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 McCormick			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	Hesmik			7/31/13	2:45 PM	7/31/13	10:53 PM	10,15	Pending													
	Doe, Guillermo	ACUSC	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
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 Violation
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: _____

INTERFAITH HOUSE
WAIT LIST

DATE ADDED TO LIST	NAME OF POTENTIAL RESIDENT	VETERAN Y or N	PRIORITIZED /OTHER Y or N	PHONE INTAKE COMPLETED	RESULTS -- CC=coming In & date **OR** CF=contacted but found other housing **OR** U = Unable To Contact / Intake Cancelled

CONFIDENTIALITY ← Standard 6.5, Standard 7.1

It is the responsibility of the Healthcare Information Department to provide for the maintenance, storage, retrieval, and distribution of healthcare information records. Other employees who are authorized to have access to a healthcare information record should follow standard operating procedures as outlined in the procedures manual. An employee authorization list is located in Healthcare Information Department with the supervisor.

All protected health information is confidential (except as designated by statute or regulations). Employees at orientation and annual evaluations should sign a confidentiality statement (see Privacy Guidelines)

All patient information should be returned to the Healthcare Information Department at the end of the day.

No medical information is to be released to any outside source without proper written authorization. Such transactions should be handled following established operating procedures.

I. INTENT:

Preserving the confidentiality of patient information is a basic tenet of Yakima Neighborhood Health Services (YNHS), as well as a requirement by law. Patients must be able to rely on the confidentiality of provider-patient communications, test results, medical histories, etc. Violation of patient confidentiality may be grounds for disciplinary action, up to and including dismissal from Yakima Neighborhood Health Services.

II. GUIDELINES:

YNHS guidelines regarding patient confidentiality apply to all staff members in all areas of the organization. These procedures also apply to information obtained for YNHS housing residents and clients served by HOPWA and HOPWA Reach. For specific information concerning patient's records, the Healthcare Information Records Manual should be consulted.

A. CONFIDENTIALITY OF PATIENT INFORMATION

Patient information, whether in the form of the documentary medical/dental record, electronic (computerized) data, or as information known to a staff member, is strictly confidential and may be disclosed only to those who are responsible for the patients' care or who have a legitimate interest in the patient's medical history. Yakima Neighborhood Health Services' healthcare providers and other staff shall have access to patient information on a need-to-know basis, and clinicians may abstract patient information for consultants to whom they refer patients. Other healthcare providers outside of Yakima Neighborhood Health Services shall have access to patient information upon receipt of a properly executed written authorization by the patient or legal representative. Procedures for responding to other types of requests for information are stated in the Healthcare information Records Manual.

Confidentiality also applies to medical/dental information about fellow employees at Yakima Neighborhood Health Services that a staff member learns during the course of his or her employment. Such information is to be protected just as strictly as is other patient information.

The documents that constitute a patient's healthcare information record are the property of Yakima Neighborhood Health Services. The original documents may not be removed from the clinic except in accordance with a specific written authorization from the Administration (i.e. Kid Screens, Home Visiting staff), or in the case of legal process a subpoena or court order, and then only if a copy of the healthcare information record will not be sufficient.

B. CONFIDENTIALITY OF NON-MEDICAL INFORMATION

Personnel, payroll, billing, insurance, and demographic information including address and date of birth are also considered to be confidential and are covered by this procedure. Employees must provide written consent for information regarding verification of employment, etc. to be released.

C. CONFIDENTIALITY OF PATIENT RELATED DISCUSSIONS

The need to protect the privacy of a patient's medical/dental information also applies to office discussions. It is easy for people to overhear conversations in public areas. Even a seemingly harmless remark overheard by another person can be embarrassing or damaging to a patient. Yakima Neighborhood Health Services staff should take care to conduct such discussion only where they cannot be overheard.

D. RELEASE OF INFORMATION

All requests for release of patient information including requests for copies of a patient's healthcare information record are to be referred to the Healthcare Information Records Department. Requests for patient information at the Sunnyside satellite clinic shall be processed by the staff at that clinic, following guidelines stated in the Healthcare Information manual. Client information is never to be on the Internet.

A general authorization for the release of medical or non-medical information is NOT sufficient for release of sensitive information. This includes information regarding mental illness, drug addiction, alcoholism, STD, or HIV tests. For more information about the release of sensitive information, consult the Healthcare Information Records Department.

E. COMPUTER SYSTEM SECURITY

Users logged into computers or terminals shall not leave them unattended without minimizing the system or invoking password-protected security features nor shall users allow others to access or edit information under the users' passwords. Passwords shall not be shared. If at any time a staff member suspects that his/her password is known by another person, (s) he must contact the Network Supervisor to cancel the

compromised password and obtain a new one. All passwords shall be changed during employee's anniversary month.

F. LONG DISTANCE PHONE CODE SECURITY
Long distance phone codes are distributed on a need to have basis by administration. Long distance calls are not to be shared, if at any time staff member suspects that another person knows his/her code, (s)he must contact his/her immediate supervisor to cancel the compromised code and obtain a new one.

G. FACSIMILE (FAX) TRANSMISSION OF CONFIDENTIAL MATERIAL
Facsimile transmission (faxing) of confidential patient information is a standard method of communicating healthcare information. Authorized staff who transmit via fax shall be responsible for ascertaining, to the best of their ability, that the receiving machine is in a secure location and that the confidentiality of the material can be preserved.

Incidents of Healthcare Information Records that have been faxed to a wrong receiver (error) should be reported on an YNHS Incident Reporting form and processed per protocol.

H. PENALTY FOR RELEASE OF CONFIDENTIAL INFORMATION WITHOUT AUTHORIZATION
A staff member of YNHS may be disciplined, and may in appropriate cases be discharged for the release of confidential patient information to an unauthorized person or organization.

I. PENALTY FOR UNAUTHORIZED RETRIEVAL OF INFORMATION
A staff member of YNHS may be disciplined, and may in appropriate cases be discharged for unauthorized or unnecessary retrieval of confidential patient information regardless of whether disclosure is made to others. Access to patient information may be made only on a need-to-know basis, in order to conduct authorized YNHS business.

J. CONFIDENTIALITY COMMITMENT
At each YNHS employee evaluation the confidentiality statement should be reviewed and re-committed to.

K. PROGRAM SPECIFIC REQUIREMENTS FOR CONFIDENTIALITY
In cases where programs require, or patients request, client records to be free of identifying names, YNHS staff should use electronic generated medical record number as client identifiers. Only authorized staff should have access to the medical record system, allowing access to identifiable information linking the record number to the individual client.

S+3 Cr 1f

Agreement to Access
Yakima Neighborhood Health Services
INFORMATION SYSTEMS

THIS AGREEMENT, is made and entered into as of 6/7, 2011 ("Effective Date"), by and between: YVMH E.D. Providers (Hospital, Clinic or Health Professional), and Yakima Neighborhood Health Services ("YNHS ") (the "Parties" or "Party").

PREAMBLES

WHEREAS, in order to carry out the goals of YNHS , it is necessary that the parties share information on a regular basis and accordingly Hospital, Clinic or Health Professional needs access to YNHS patient information; and

WHEREAS, YNHS's information systems contains confidential patient information, along with proprietary information (collectively "Information"); and

WHEREAS, the Parties desire to enter into this Agreement to ensure the Information available to Hospital, Clinic or Health Professional is maintained confidentially;

NOW THEREFORE, in consideration of the premises, the mutual covenants and agreements contained herein, the Parties agree as follows:

ARTICLE 1

Duties of Hospital, Clinic or Health Professional

1.1 Access to Information Systems. The Parties acknowledge that from time to time Hospital, Clinic or Health Professional may be provided access to specific YNHS information systems. When such access is provided the terms of this Agreement shall be applicable. Nothing in this Agreement shall be intended to guarantee access to any specific YNHS information systems. The Hospital and Provider agrees that it will use its access to YNHS information systems for the specific purpose of providing health services to YNHS patients, and /or patients shared between YNHS and the Hospital, Clinic or Health Professional.

1.2 Access to Patient Records. Hospital, Clinic or Health Professional agrees to only access patient records of which they have a direct patient care relationship. Accessing individual records of patients within YNHS's information systems of which Hospital, Clinic or Health Professional does not have a current, direct patient care relationship is strictly prohibited. Such prohibited access could result in removal of access privileges for specific individuals or entirely for Hospital, Clinic or Health Professional.

1.3 Confidentiality of Proprietary Information. Hospital, Clinic or Health Professional and YNHS agree that all Information of YNHS's that comes to Hospital, Clinic or Health Professional by way of its access to YNHS information systems is confidential or proprietary. This provision shall survive the termination of this Agreement.

1.4 Confidentiality of Patient Records. All medical information and/or data concerning specific patients (including, but not limited to, the identity of the patients), derived from or obtained during the course of Hospital, Clinic or Health Professional access under this Agreement, shall be treated by the Hospital, Clinic or Health Professional and YNHS as confidential so as to comply with all applicable state and federal laws and regulations regarding confidentiality of patient records, and shall not be released, disclosed, or published to any party other than as required or permitted under applicable laws. This provision shall survive the termination of this Agreement.

1.5 Confidentiality Policies. During the term of this Agreement, Hospital, Clinic or Health Professional agrees to maintain appropriate confidential and security policies to ensure that the terms of this Agreement are carried out. Such policies shall include the safeguarding, nondisclosure and use of access codes (PIN's, user names, and passwords, etc.).

1.6 Control Over Employees. Hospital, Clinic or Health Professional is solely responsible for the acts of its employees and agrees, prior to providing its employees access to a YNHS information system, to have the employee sign the Confidentiality Statement (Exhibit A). Hospital, Clinic or Health Professional will provide all executed Individual Confidentiality Statements to YNHS and retain a copy in its files.

1.7 Termination of Employment and Account Inactivity. Hospital, Clinic or Health Professional is solely responsible for immediately notifying YNHS when its employee with access to YNHS information systems terminates employment for any reason. Upon notification of terminated employment, YNHS will deactivate system access. Furthermore, YNHS may deactivate specific user accounts that have not been used for a 90-day period. Hospital and Provider agrees not to reuse or share any user access accounts.

1.8 Audit of User Accounts. YNHS will periodically audit access to information systems and notify Hospital and Provider of any findings. Hospital and Provider will promptly cooperate with YNHS audit procedures, investigate suspected violations and take appropriate action on any confirmed misuse of systems or improper disclosure of protected information.

1.9 Notification of Improper Use or Disclosure. Hospital and Provider will promptly notify YNHS in writing of any improper disclosure, misappropriation, or misuse of any Information by any person, which may come to the attention of Hospital and Provider.

ARTICLE 2

HIPAA Requirements

Notwithstanding any other part of this Agreement, Hospital and Provider agrees that to the extent the Information is "protected health information", as defined by the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated there under ("HIPAA"), it will comply with the requirements of HIPAA and:

(a) protect the privacy of such "protected health information" in accordance with the most restrictive legal requirements applicable to it or to YNHS;

(b) use appropriate safeguards and take all reasonable and necessary steps to prevent unauthorized or improper disclosure and use of such "protected health information"; and

(c) include the requirements of this Article in any agreement or arrangement with any subcontractor with whom it contracts with respect to such health data or with any person to whom it will provide or allow access to any or all of such health data. To the extent required by HIPAA, any person whose "protected health information" is provided or accessed as a result of the Hospital and Provider access to YNHS information systems shall be considered a third-party beneficiary of this Agreement.

Hospital and Provider agrees that it will execute a Business Associate Agreement provided by YNHS if such is determined to be necessary under the provisions of HIPAA.

ARTICLE 3

Revocation of Access

The access of Hospital and Provider and any of its specific employees, to YNHS's information systems is subject to periodic review, revision or revocation. YNHS may at any time for any reason or for no reason revoke the access of Hospital and Provider or one or more of its employees to one or more YNHS information systems.

ARTICLE 4

Term and Termination

This Agreement shall be effective as of the Effective Date and shall continue until the business affiliation is terminated or until the Parties mutually agree to terminate this Agreement.

ARTICLE 5

Remedies

YNHS agrees that money damages would not be sufficient remedy for any breach or threatened breach of this agreement and that therefore, in addition to all other remedies, YNHS shall be entitled to specific performance and injunctive or other equitable relief as a remedy for any such breach or threatened breach and to recover all costs and disbursements incurred in obtaining such relief including reasonable attorneys' fees. Hospital and Provider shall defend, hold harmless and indemnify YNHS against any and all claims, liabilities, damages, judgments, costs and expenses (including reasonable attorney's fees and costs) asserted against, imposed upon or incurred by Memorial Hospital that arises out of, or in connection with Hospital and Provider default under or failure to perform any contractual or other obligations, commitment or undertaking under this Agreement, or any other act or omission of The Clinic or its employees, agents or representatives with respect to this Agreement. The provision of this Article 6 shall

survive termination of the Agreement with respect to any claim, action, or proceeding that relates to acts or omissions occurring during the term of this Agreement.

ARTICLE 6

Miscellaneous

6.1 Amendments. This Agreement and the Exhibits may be amended only upon the mutual written consent of the Parties.

6.2 Independent Contractors. YNHS and Hospital / Provider are at all times serving as independent contractors hereunder. Nothing in this Agreement shall be, construed to make or render either Party or any of its officers, agents, or employees an employee of, or joint venturer of or with the other for any purpose whatsoever. No right or authority is granted to Hospital and Provider to assume or to create any obligation or responsibility, express or implied, on behalf of or in the name of YNHS.

6.3 Notices. All notices hereunder by either party to the other shall be in writing. All notices, demands and requests shall be deemed given when mailed, postage prepaid, registered or certified mail, return receipt requested:

If to The Hospital or Provider at: YVMH ED
ATTN: Medical Director
2811 Tieton Dr.
Yakima, WA 98902

If to YNHS at:
Yakima Neighborhood Health Services
Attn: Chief Executive Officer
PO Box 2605
Yakima, Washington 98907-2605

or to such other address or to such other person as may be designated by written notice given from time to time during the term of this Agreement by one party to the other.

6.4 Entire Agreement. This Agreement represents the entire agreement and understanding of the Parties hereto with respect to the subject matter hereof, and all prior and concurrent agreements, understandings, representations and warranties with respect to such subject matter, whether written or oral, are and have been merged herein and superseded hereby.

6.5 Compliance With Terms. Failure to insist upon strict compliance with any of the terms herein (by way of waiver or breach) by either Party hereto shall not be deemed to be a continuous waiver in the event of any future breach or waiver of any condition hereunder.

6.6 Rights of Parties. Nothing in this Agreement, whether expressed or implied, is intended to confer any rights or remedies under or by reason of this Agreement on any persons other than the Parties to this Agreement and to their respective successors and assigns.

6.7 Assignment. This Agreement may not be assigned by either Party without the express written consent of the other Party.

6.8 Benefits. This Agreement shall be binding upon, and shall inure to the benefit of, the Parties hereto and their respective heirs, personal representatives, executors, administrators, successors and assigns.

6.9 Construction. Wherever possible, each provision of this Agreement will be interpreted so that it is valid under the applicable law. If any provision of this Agreement is to any extent invalid under the applicable law, that provision will still be effective to the extent it remains valid. The remainder of this Agreement also will continue to be valid, and the entire Agreement will continue to be valid in other jurisdictions.

6.10 Captions. The headings in this Agreement are for convenience only and do not affect this Agreement's interpretation.

6.11 Multiple Counterparts. This Agreement may be executed in multiple counterparts, each of which shall be deemed to be an original and all of which taken together shall constitute a single instrument.

6.12 Conflict of Laws. This Agreement shall be governed by the laws of the state of Washington without giving effect to its conflicts of law provisions.

IN WITNESS WHEREOF, the parties hereto have set their hands on the dates set forth below.

HOSPITAL/PROVIDER	**YNHS** **Yakima Neighborhood Health Services**
By Erik Miller MD/Director	By
Its Erik C Miller 6/7/14	Its CEO

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, develop 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.

Client Consent Form for Data Sharing

Version 1.3, Adopted 01/14/2015

Participating Agency Information

Interfaith House

3456 W Franklin Blvd

Chicago, IL 60624

What are you consenting to? This Agency is a participating agency using the Homeless Management Information System ("HMIS"). HMIS participating agencies work together to provide services to persons and families in need. When you request or receive services, we may collect data about you and your household that may be shared with other HMIS participating agencies.

How will my data be used? Your information will be used for statistics, such as the number of persons that are homeless or at risk of homelessness, and to share information with other agencies that serve persons in need of assistance. The specific ways in which this agency may use or disclose your information is stated in our Standard Agency Privacy Practices Notice. You can request a copy of the Standard Agency Privacy Practices Notice at any time.

How will my data be protected? The data stored in the HMIS will be protected by passwords and encryption technology. In addition, each participating agency must sign an agreement to maintain the security and confidentiality of the information you have provided. Any person or agency that violates the agreement may have their access right terminated and may be subject to further penalties.

How do I benefit by providing the requested information and sharing it with other agencies? By sharing your information with other agencies, you may be able to avoid being screened again, receive services faster, and minimize how many times you have to tell your "story." You also help agencies document the need for services and funding, better understand homelessness, and evaluate the effectiveness of our services.

What data will be shared with other agencies that use HMIS?

The following pieces of information used for primary identification purposes can be seen by other agencies that use HMIS:

- Name
- Date of Birth
- Veteran Status
- Social Security Number
- Gender

By signing this form, I agree to share the following level of information with other HMIS participating agencies:

☐ I agree to share my primary identifying information (as listed above)

☐ I do not agree to share any of my information with other HMIS participating agencies

In addition, by signing this form, I acknowledge and agree to the following:

- The Standard Agency Privacy Practices Notice describes the ways in which the primary identifying information and other HMIS client data information may be used or disclosed.
- I have the right to revoke this consent at any time by completing a Client Revocation Form. I understand that the revocation will not be retroactive to any information that has already been used or disclosed.
- I may request a paper copy of the complete Standard Agency Privacy Practices Notice from this Agency.
- I am not giving permission to share information about the diagnosis or treatment of a mental health disorder, drug, or alcohol disorder, HIV, AIDS, or domestic violence concerns.
- I have read the information in the Standard Agency Privacy Practices Notices.

Printed Name(s) (including children)

Signature of Client or Guardian | Date | Signature of Agency Witness | Date

INTERFAITH HOUSE

HEALTH SERVICES COLLABORATIVE PARTNERS

Heartland Health Outreach, PCC Wellness Center & Rush College of Nursing

Consent for Treatment and Record Review &
Acknowledgement of Privacy Policy

The Interfaith House Health Services Collaborative is dedicated to making sure that all residents of Interfaith House have the opportunity to access medical care by:

- Providing a primary care physician or nurse practitioner and offering preventive health services
- Helping residents get medicines
- Arranging follow-up care after leaving Interfaith House

To do this, we need your permission to provide you with medical treatment and to let us share information with the other people involved in your care. Please read the following statement and sign this form if you consent.

Consent & Acknowledgement

I agree to receive medical treatment from the Interfaith House Collaborative Health Partners. I consent to:

- Let clinic providers (doctors and nurse practitioners) look at all my Interfaith House records.
- Let Interfaith House non-medical staff review my clinic records.
- Let the clinic send my medical records to the medical provider I follow up with when I leave Interfaith House.
- Let the clinic release my information to insurers for billing purposes.
- Let the provider I follow up with share information about my medical status with the clinic.
- Have my records reviewed by the Chicago Department of Public Health, which helps to fund the clinic.

I have received the Health Services Collaborative Notice of Privacy Practices, which explains my rights to see and copy my records, decide who can receive any of my health information, and request that information in my chart be changed. I understand that I can change my mind about who gets to see my health information, although this will not affect health information that has already been shared with my consent. If I change my mind, I must let the Collaborative Health Partners know in writing.

Name of patient (printed)	Signature	Date

Name of Witness (printed)	Signature	Date

Revised March 2014

Med Rec# _____

YNHS 2015 PATIENT REGISTRATION / SLIDING FEE APPLICATION AND CONSENT FOR CARE

Patient Name _____ DOB ____/____/_____
Social Security # _____--____--_____ Other Names You Go By: _____
Current Address _____
Street / PO Box City Zip
Daytime Phone _____ Message#_____ Who is this? _____
Email Address _____
Preferred Contact: Mail Phone **Message OK ?** YES NO | **OK to Mail things to your home ?** Yes No

Please tell us about your living situation. All information is CONFIDENTIAL:

___ I / we have been homeless in the last year and have housing now (Transitional)
___Staying with friends/relatives (Doubling Up, Sofa Surfing)
___Staying in a shelter (Short term housing like the Mission, YWCA, Calvary, New Hope, etc.)
___Staying in a treatment facility (Transitional)
___Living in public housing (apartments or duplexes) where all the tenants get discounted rent .
___Living on the street, outdoors, or in a car/travel trailer/camper (Street)
___Living somewhere not meant to be a home – no running water or heat (Other homeless)
___We have concerns about our housing and want to discuss this with a supervisor in private. (Other)
___We own / rent our own home without help. Our housing situation is stable.

Is the Patient Hispanic (circle) ? Yes No **Is the Patient a Smoker ?** Yes No

PATIENT RACE(circle): Asian Native Hawaiian Other Pacific Islander
African American/Black American Indian/ Alaska Native White Multi-Racial

IF 18 or Older, HAS THE PATIENT BEEN IN THE MILITARY ? (circle)? Yes No

Is there anyone (family / friend) you want to give our providers permission to talk to about your medical / dental condition(s)?
Name _____ Relationship _____
Name _____ Relationship _____

What kind of Medical Coverage do you have? (We'll need to make a copy of your card)
Apple Health /Healthy Options Medicare Private Insurance None
Other _____
Do You Receive (circle): Basic Food WIC VA Benefits SSI
(This information tells us if you qualify for medical, dental, or pharmacy discounts):
Current Household Monthly Income $_____ . How many people live in your household? _____
Is your Household Income dependent Migrant Farm Work? **YES NO** (circle) Seasonal Farm Work? **YES NO** (circle)

- ☐ I give my permission for the above named patient to receive treatment which the attending medical or dental practitioner considers necessary.
- ☐ I understand my financial obligation. If I have insurance (including Medicaid and Medicare) I authorize my insurance company or payor of services, to obtain information from YNHS for the purpose of determining payment for my care. If I do not have insurance, I understand my ability to pay has been determined based on the information I have given to YNHS staff on this form. I understand I may be charged a fee if I fail to keep my scheduled appointment and do not cancel before the scheduled appointment time. I understand my insurance (including Medicaid and Medicare) will not pay this for me.

_____ _____
Signature of patient/guardian date Staff Signature / Interpretation needed? Y N date

2015 PATIENT REGISTRATION / SLIDING FEE APPLICATION/ CONSENT FOR CARE
(Page 2)

Patient Name _____ Medical Record # _____

Current Household Monthly Income $_____ . How many people live on this income? _____

HHSiz	0-100% FPL			101-125% FPL			126-150% FPL			151-200% FPL			201% FPL
1 yr	$ -	-	$ 11,770	$ 11,771	-	$ 14,713	$ 14,714	-	$17,655	$17,656	-	$ 23,540	$ 23,541
1 mo	$ -	-	$ 981	$ 982	-	$ 1,226	$ 1,227	-	$ 1,471	$ 1,472	-	$ 1,962	$ 1,963
2 yr	$ -	-	$ 15,930	$ 15,931	-	$ 19,913	$ 19,914	-	$23,895	$23,896	-	$ 31,860	$ 31,861
2 mo	$ -	-	$ 1,328	$ 1,329	-	$ 1,659	$ 1,660	-	$ 1,991	$ 1,992	-	$ 2,655	$ 2,656
3 yr	$ -	-	$ 20,090	$ 20,091	-	$ 25,113	$ 25,114	-	$30,135	$30,136	-	$ 40,180	$ 40,181
3 mo	$ -	-	$ 1,674	$ 1,675	-	$ 2,093	$ 2,094	-	$ 2,511	$ 2,512	-	$ 3,348	$ 3,349
4 yr	$ -	-	$ 24,250	$ 24,251	-	$ 30,313	$ 30,314	-	$36,375	$36,376	-	$ 48,500	$ 48,501
4 mo	$ -	-	$ 2,021	$ 2,022	-	$ 2,526	$ 2,527	-	$ 3,031	$ 3,032	-	$ 4,042	$ 4,043
5 yr	$ -	-	$ 28,410	$ 28,411	-	$ 35,513	$ 35,514	-	$42,615	$42,616	-	$ 56,820	$ 56,821
5 mo	$ -	-	$ 2,368	$ 2,369	-	$ 2,959	$ 2,960	-	$ 3,551	$ 3,552	-	$ 4,735	$ 4,736
6 yr	$ -	-	$ 32,570	$ 32,571	-	$ 40,713	$ 40,714	-	$48,855	$48,856	-	$ 65,140	$ 65,141
6 mo	$ -	-	$ 2,714	$ 2,715	-	$ 3,393	$ 3,394	-	$ 4,071	$ 4,072	-	$ 5,428	$ 5,429
7 yr	$ -	-	$ 36,730	$ 36,731	-	$ 45,913	$ 45,914	-	$55,095	$55,096	-	$ 73,460	$ 73,461
7 mo	$ -	-	$ 3,061	$ 3,062	-	$ 3,826	$ 3,827	-	$ 4,591	$ 4,592	-	$ 6,122	$ 6,123
8 yr	$ -	-	$ 40,890	$ 40,891	-	$ 51,113	$ 51,114	-	$61,335	$61,336	-	$ 81,780	$ 81,781
8 mo	$ -	-	$ 3,408	$ 3,409	-	$ 4,259	$ 4,260	-	$ 5,111	$ 5,112	-	$ 6,815	$ 6,816
9 yr	$ -	-	$ 45,050	$ 45,051	-	$ 56,313	$ 56,314	-	$67,575	$67,576	-	$ 90,100	$ 90,101
9 mo	$ -	-	$ 3,754	$ 3,755	-	$ 4,693	$ 4,694	-	$ 5,631	$ 5,632	-	$ 7,508	$ 7,509
10 yr	$ -	-	$ 49,210	$ 49,211	-	$ 61,513	$ 61,514	-	$73,815	$73,816	-	$ 98,420	$ 98,421
10 mo	$ -	-	$ 4,101	$ 4,102	-	$ 5,126	$ 5,127	-	$ 6,151	$ 6,152	-	$ 8,202	$ 8,203
Ea yr	$ -	-	$ 4,160	$ 4,161	-	$ 5,200	$ 5,201		$ 6,240	$ 6,241	-	$ 8,320	$ 8,321
Ea mo	$ -	-	$ 347	$ 348	-	$ 433	$ 434		$ 520	$ 521	-	$ 693	$ 694

Reception / Intake Staff :

(yes or n/a)

Uninsured patients / IPA scheduled _____

Patient Portal - Token Given /Patient Enrolled _____

_____

Staff Signature / Interpretation needed? Y N date

TOPIC: MEDICATION REFILLS

PURPOSE: To provide guidelines for refilling prescription medication of PCC Community Wellness Center patients.

LEVEL OF RESPONSIBILITY:

Providers
Registered Nurses
Patient Care Representatives

POLICY: PCC Community Wellness Center recognizes the importance of ensuring that patients are able to refill their prescription medications in a timely manner while ensuring the safety of each patient.

PROCEDURE:

1. All faxed requests for medication refills will be collected by designated staff and given to designated nurse or provider along with patient chart once each session Monday thru Friday following these guidelines:
   - Can be refilled by RN:
     - Can refill up to 6 months of well documented chronic medications if seen within last 6 months.
     - Contraception can be bridged/extended for 1-3 months after anniversary of last annual exam but must assist patient in scheduling follow up appointment.
   - Must be referred to provider:
     - Patients who have not been seen by a Provider within last year
     - If failed to make appointments after refill extension/bridge, they are to see their Provider.
     - All Narcotics, Benzodiazepines, and Psychotropic meds.
     - Acute medications (i.e. antifunguls, antibiotics, steroid creams, vaginal creams).
     - Statins (for LFT monitoring assurance) and coumadin, digoxin, and seizure medications (all of which require levels).
     - Dosage changes
     - Formulary changes

2. Providers and/or RNs should check eprescribing system prescription refills on a regular basis.

3. All refills should be signed by a provider as soon as possible.
   - If meets guidelines, triage RN authorizes refill and forwards chart for provider to co-sign (including the charts of electronically signed prescriptions) in site designated area.
   - If refill does not meet automatic refill guidelines, refer refill and chart to providers.

Original: 2/09
Revised: 2/10

interfaithHOUSE
Restoring health, rebuilding lives, returning home.

SIGNED MEDICAL DIAGNOSIS

Client name: _____

SSN: _____ Date of birth: ____/____/_____

Referring institution: _____

Primary acute diagnosis: _____

Other medical diagnoses: _____

Client has a disability: _____ Yes _____ No Disability type: _____Physical _____ Mental

Based on the patient's medical diagnoses, s/he:

_____ *SHOULD* apply for disability benefits.

_____ *SHOULD NOT* apply for disability benefits.

_____ Patient already has disability benefits.

If the client is impacted by HIV/AIDS, please complete the following:

Date of HIV diagnosis: ____/____/_____

Date of AIDS diagnosis (if applicable): ____/____/_____

Location of HIV/AIDS treatment: _____

CD4 count: _____ Date of test: ____/____/_____

Viral load: _____ Date of test: ____/____/_____

TB test results: _____ Date of test: ____/____/_____

Current status (please check):

____ HIV-Asymptomatic ____ HIV-Symptomatic ____AIDS

Physician's Signature: _____ Date: ____/____/_____

Please fax to (773) 533-9034

All Staff - Counting Residents' Controlled Medications

Policy

In efforts to sake-keep our residents' medications, prescribed medications that have a high likelihood for misuse or abuse should be closely monitored. The following procedure should occur.

Procedure

1. Resident life should inspect all new medications that are turned in by residents.
2. The following medications should be identified for counting with the resident present:
   - ❑ Narcotic pain relievers (e.g. any medication containing morphine or codeine)
   - ❑ Methadone
   - ❑ Clonidine
   - ❑ Tranquilizers (e.g. Xanax, Lithium, Valium, Ativan, Benzodiazepine)
   - ❑ Barbituates (e.g. Phenobarbital)
   - ❑ Stimulants (e.g. Ritalin)
   - ❑ Ibuprofen 600 or 800 mg
3. If Central Desk is unable to count the medication when it is turned in, the medication should be sealed in a bag until time permits.
4. When Central Desk is able to count the medication (those listed in #2), the resident should be present to act as a witness.
5. If the resident is missing pills and it appears that the medication bottle or bag has been tampered/opened, Central Desk staff should notify their Supervisor.
6. If the resident is missing pills, but it does not appear that the medication bottle or bag has been opened, staff will inform the resident to double check the count of medication at the Pharmacy so they will not be held accountable for missing medications.
7. There may be a room and locker search if the cause of the missing pills is not determined through the pharmacy.
8. The resident will be put on a behavior contract if they are missing a significant number of pills and the bottle appears to have been tampered with.

_____ ____/____/_____

Executive Director Date

Interfaith House
Health Services – Medication Policy and Procedure

Policy

All program staff are responsible for the monitoring of resident medications, staff are trained as a part of their orientation to Interfaith House and as policies and procedures change or are updated they are informed and retrained. All residents are responsible for obtaining their own medications prior to their arrival and throughout their stay. Interfaith House does not administer medications but only assumes responsibility for their safekeeping, and monitors their distribution. Medications are stored and locked in the medication room and the keys are kept at Central Desk..Upon intake all medications are logged, the number of pills and the frequency is also logged on the individual's medication sheet; controlled medications are also counted and logged on a separate sheet and counted each time a resident takes one. All resident medications are stored in the respective resident's assigned drawer or refrigerator according to manufacturer's recommendations. Residents are not permitted to share their prescribed medications with other residents.

Procedure

1. Each resident is required to arrive with a 30-day supply of medication. Obtaining medication is the responsibility of the resident and his/her health-care provider. Refills or new medications needed during a resident's stay are also the responsibility of the resident. Each resident is responsible for meeting with the appropriate medical care professional in order to refill his/her medications.
2. Each resident's medications are counted and documented on the *Medication List* upon arrival. A *Medication List* is placed in each resident's file and medications are placed into each resident's medication drawer in the medication room. Medication forms are to be filled out according to the *Medication Box Procedure* sheet.
3. Residents who require medication must report to the medication room during the scheduled daily medication times. If a resident needs to take PRN medication not during one of the scheduled medication times, an RCA or other staff member will assist the resident. Residents are responsible for taking medications as prescribed by their physicians. Any adverse side effects, interactions or allergic

reactions are discussed with the medical staff. The Staff is responsible for observing and recording all medications taken by residents.

4. All medications must be put away after use and never left unattended in the medication room. The medication room should be locked whenever it is unattended.

5. Please refer to the current *Controlled Medications* sheet for a list of all controlled medications. In the event that there is a discrepancy in the count of a controlled medication, a senior staff member will be notified.

6. Discontinued or expired medications will be removed by Staff or an MCP to be stored and picked-up by stericycle for the safe disposal of this medication. In addition, discontinued medication will be recorded as such in the resident's chart.

_____ _____

Jennifer Nelson-Seals, Executive Director

Date:

JWCH INSTITUTE, INC. Health & Medical Services

S3: C-11
Click here to return to Standards Page

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

Exibit B

Yakima Valley Memorial Hospital
Acceptable Use Policy For Clinic Staff

Purpose

Yakima Valley Memorial Hospital (YVMH) is responsible for securing its computer systems, associated data, and communications network. In addition, any person accessing such systems is responsible for preventing the occurrence of inappropriate, unethical, or unlawful use of such systems and data.

General Principles

Access to computer systems and networks owned or operated by YVMH imposes certain responsibilities and obligations, and is granted subject to Hospital policies, local, state, and federal laws*. Acceptable use is always ethical, legal, and maintains patient confidentiality, protects the interests of YVMH, and shows restraint in the consumption of shared system resources.

Guidelines

Acceptable Use

Acceptable use of information systems includes, but is not limited to:

- Using computing resources only for authorized purposes.
- Protecting your user-ID and password from unauthorized use. You are responsible for all activities associated with your user-ID.
- Accessing only files and data that are your own, which are publicly available, or to which you have been given authorized access.

Unacceptable Use

Unacceptable use of information systems includes, but is not limited to:

- Using another person's user-ID or password.
- Attempting to circumvent or subvert system or network security measures.
- Engaging in any activity that might be harmful to YVMH systems or to any information stored thereon, such as the creation or propagation of viruses, disruption of services, or damage to files.
- Using YVMH systems for commercial, political, or extensive personal use.
- Engaging in any other activity that does not comply with the general principles presented above.

Enforcement

YVMH considers any violation of acceptable use principles and guidelines to be a serious offense and reserves the right to deny continued access to its systems and data. Violators could be subject to disciplinary action by their employer and possible legal action by Memorial Hospital or other appropriate agencies with jurisdiction.

I have read and understand the principles and guidelines represented in the document.

Printed Name

Signature Date

Applicable laws include, but are not limited to, the *Privacy Protection Act of 1974,* the *Computer Fraud and Abuse Act of 1986,* the *Computer Virus Eradication Act of 1989, Interstate Transportation of Stolen Property,* the *Electronic Communications Privacy Act*, the *Digital Millennium Copyright Act,* and the *Health Insurance Portability and Accountability Act of 1996*.

Name_____ DOB_____ MRN_____
Last First MI

ICM: Mom's Name_____ DOB_____ Visit Date_____

Address_____ SSN_____

City_____ State_____ Zip+4_____ Home Phone_____

Language: ·English ·Spanish ·Other_____ Day Phone_____

Marital Status: · Divorced · Married ·Legally Separated · Single · Widow	Contact Preference ·Alternate Phone ·Home Phone ·Day Phone ·Mail ·Email ·Text Message ·Secondary Hm Phone
Student Status: · Full-time · Not a student · Part-time	
Smoker: · Yes · No	
Disabled/Handicapped: · Yes · No	**Family Size: _____ Number < 18 _____**
Immigrant/Refugee: · Yes · No	**Household Status: · Individual · Two Parent · Single Female HOH · Single Male HOH**

Employment Status: · Full-time · Part-time · Not Employed · Active Duty · Self-employed

Homeless Status: ·Doubling Up · Not Homeless ·Other ·Public Housing ·Shelter ·Street · Transitional	**Migrant Worker Status: ·Migrant · Not a Farm Worker · Seasonal**	**Language Barrier: · Yes · No**
Race: · American Indian or Alaska Native · Asian · Black/African American · More Than One Race · Native Hawaiian · Other Pacific Islander · Unreported/Refused · White	**Ethnicity: Do you consider yourself Hispanic or Latino? · Yes · No · Other or Unreported**	
Primary Medical Coverage: Medicaid? · Yes · No P1 #_____ Assigned to a plan? · Yes · No If yes, plan name _____	**Veteran: · Yes · No**	

Responsible Party: Income _____ · Week · Month · Year

Emergency Contact: Name _____Phone _____

Marketing Plan:

*Other YNHS Services	Radio	Farmers Market
*YNHS @Community Outreach	Television	In Person Assister Referred
*Other Community Provider	Newspaper	Movie Theater
*Other Provider-Outside Yakima County		Family/Friends/Neighbors

Marketing Data: If an * item was chosen for Marketing Plan, note the specific source/place/provider

_____

NPP Date:_____

Provider Signature _____

TOPIC: MEDICAL RECORDS, MAINTENANCE OF

PURPOSE: To serve as a basis for planning patient care and for continuity in the evaluation of the patient's condition and treatment.

To provide a chronological summary of the patient's medical evaluation, treatment and change in condition.

To document communication between the responsible practitioner and any other health professional contributing to the patient's care.

LEVEL OF RESPONSIBILITY:

Providers
Students
Residents
Nurses
Medical Assistants
Clerical Staff

POLICY:

It is the policy of PCC Community Wellness Center to maintain medical records that are accurate and timely; that are readily accessible, and that permit prompt retrieval of information. The record shall contain information to identify the patient, to support the diagnosis, to justify the treatment, and to accurately record the patient's clinical course.

PROCEDURES:

Medical Record Standards

1. Content of the Medical Records
    a) All medical records shall contain at least the following information:
        - Patient identification/demographic data
        - History and Physical examination completed by the third visit or a year after the first visit, whichever comes first
        - Problem and medication lists completed by the third visit or a year after the first visit, whichever comes first
        - Evidence of appropriately informed consent for treatment and procedures
        - Reports of procedures and tests
        - Clinical progress notes

Medical Record Entries

a) Entries in medical records shall be made only by individuals given the right as specified in PCC Community Wellness Center policies.
b) Entries shall be made at the time of the patient's visit.
c) Only approved clinic abbreviations will be used in chart notations.
d) All orders must be signed by a provider. Verbal and telephone orders must be signed within 24 hours.
e) Specific instructions for nursing personnel:
    - Pertinent observations, patient's statements about condition, changes in the patient's condition must be documented in EHR on proper encounter form
    - Document patient related calls using a PHONE NOTE and route to provider and indicate the reason for the call
    - All professional teaching must be documented on the progress notes and must include what was taught. If handouts generated through EHR, user should check box to record in chart.

Original: 3/98
Revised: 5/02, 9/02, 8/05, 6/11, 5/12

TOPIC: MEDICAL RECORDS, PRIVACY AND RELEASE OF PCC

PURPOSE: To ensure the privacy of medical information and ensure that medical information is released only to authorized parties.
To ensure patient's privacy and rights as well as guarantee patient's rights of privileged communication.
To ensure that original medical records are released by PCC Community Wellness Center only in accordance with Federal and State Laws, court orders or subpoenas.

POLICY: The patient medical record, and all the information it contains, is a legal document and privacy of protected health information is to be safeguarded. The medical record and its contents are to be available only for authorized staff employed or contracted by the clinic. PCC Community Wellness Center recognizes that at times there is a need to share patient information with other institutions, organizations or individuals. This information is, however, private and requires that strict guidelines be followed and proper authorization be received prior to release of any patient information.

LEVEL OF RESPONSIBILITIES:

All Staff

PROCEDURE:

1. The medical record is the property of the Center and is maintained for the benefit of the patient, the medical staff and the Center. Its primary purposes are to serve as a basis for planning patient care and for continuity in the evaluation of the patient's condition and treatment; to furnish documentary evidence of the course of the patient's medical evaluation, treatment, and change in condition; to assist in protecting the legal interest of the patient, the Center, and the provider responsible for the patient; and to provide data for use in continuing education.

2. The medical record is strictly privileged and shall be available only to authorized individuals (those individuals having a legitimate need and valid authorization for access to the record). The patient or his authorized representative shall have access to the medical record pursuant to this policy and procedure.

3. Medical records may be removed from the Center's jurisdiction and safekeeping only in accordance with a court order, which does not require patient authorization or patient notification. Subpoenas should be accompanied either by a patient's signed authorization or include a statement that the patient was notified of the subpoena, given the opportunity to object and has not objected.

4. The medical record shall be defined as the composite document containing identification information, reports of clinical examination and treatment and ancillary reports of tests, exams, care and treatment.

5. The Center shall comply with valid requests for medical records within a reasonable time period. All requests shall be directed to the Medical Records Department for appropriate disposition.

6. Prior to printing Centricity EHRS, TREENO or copying any paper medical records, medical records staff should review the medical record to ensure all notes/documentation are signed and there are no outstanding documents that need to be scanned into the patients EHR..

Valid Authorization of Patient Medical Record

Information from medical records may be released pursuant to a valid authorization. The authorization must be in writing and should include the following data:

a. Addressed to PCC Community Wellness Center
b. The patient's full name and date of birth
c. The name and address of the individual or agency to which the information is being released.
d. The purpose or need for medical information
e. The exact information needed from the medical record (both by date and specifics of part(s) of record being requested) including sensitive information such as HIV/AIDS information, records of alcohol or drug abuse treatment or mental health treatment.
f. Something that states the authorization may be revoked in writing.
g. Something stating the information has the potential to be redisclosed
h. Something stating that treatment, payment or eligibility may not be conditioned on obtaining the patient's authorization.
i. Patient or their representative's signature (if representative, should include court orders, power of attorney for healthcare papers, death certificates, estate papers, guardianship papers, adoption papers, etc.) The signature of the patient or other authorized individual with substantiating documents when necessary. The authorizing signature should be compared with a signature in the medical record for authenticity. If the record contains no signature for comparison, verification of identity and authority must be ensured. (See Verification of Identity and Authority Policy and Procedure).
j. An expiration date
k. The method in which the records should be released (electronic copy CD, mailed, faxed).

In the event that the authorization is found to be inadequate (missing one of the above stated items), medical records staff should fax or mail requestor PCC's "Inadequate Authorization" letter (see attached) along with the original request. A copy of both should be filed in the medical record or scanned into the EHR.

Authorized Release of Information

The following individuals may authorize the release of information from the medical records upon signing a valid authorization:

1. Competent adult patients.
2. A guardian, if the patient is a minor under 18 years of age.
3. A guardian, if the patient is legally judged incompetent.
4. Emancipated minor.
5. The executor, administrator or personal representative of a deceased patient.

NOTE: The guardian of a patient who is at least 12, but under 18 years of age, may inspect and request a copy of the medical record with the exception of any information pertaining to the minor seeking treatment for a sexually transmitted diseases, drug or alcohol use and family planning. If any visits pertain to any of these areas, the minor MUST authorize the release of this information. In addition, the guardian of a patient who is at least 12, but under 18 years of age, may inspect and request a copy of the patient's mental health record, if the recipient is informed and does not object or if the therapist does not find that there are compelling reasons for denying access. The guardian who is denied access by the patient or the therapist may petition a court for access to the record.

Telephone Requests

Verbal requests for the release of medical information are discouraged and limited to emergency situations only. Such a request is generally initiated by a provider and is for the benefit of the patient. Reasonable verification of identity should occur before release of protected health information.

Access to Medical Records

In accordance with Illinois law, a patient, his provider or authorized attorney shall be permitted to inspect and/or have copies made of the patient's medical record upon presentation of a valid authorization. All requests from attorneys should be directed to the Director of PI.

Patients are permitted to review their original medical records, but only in the presence of their provider. A time should be scheduled when the provider is available to review the entire chart with the patient.

Requested records should be processed in 3 business days ~~received within 3 weeks.~~

Release to Attorneys

1. Information from a patient's medical record may not be released to the patient's attorney without a valid authorization in the form of a signed patient authorization or court order.

2. The Center will comply with all valid subpoenas. A valid subpoena consists at a minimum of the following: originator, signature, original seal and a docket number as well as either an authorization from patient or legal guardian for release of records or documentation that the patient whose records are being requested has been notified of subpoena, given the opportunity to object to request and has not objected.

3. All requests from attorneys should be directed to the Director of PI with the medical record.

Release of Information Pursuant to Illinois Worker's Compensation Act
1. If a case is pending at the Illinois Industrial Commission pursuant to the Worker's Compensation Act, the patient's medical records may be released, upon written request, to any party to the proceeding (i.e. the employee or his dependents, the employer, or their attorneys).

Release of Information in Cases of Public Record
1. In cases of public record (i.e. when the patient is a public figure or a victim of a newsworthy occurrence, such as an accident or crime) information may not be disclosed without the valid authorization of the patient or his authorized representative and notification of the Chief Executive Officer.

In all cases, PCC Community Wellness Center will use and disclose information at a level consistent with the minimum amount necessary to fulfill the function for which the disclosure of information is intended. PCC Community Wellness Center will not disclose an entire medical record, except for treatment purposes or when the entire record is specifically justified.

When a request for information is made, without authorization of the patient, staff should instruct caller that a valid authorization from the patient is needed and provide them with PCC's "Authorization to Release Medical Records" form. Any additional questions should be directed to the Director of PI. If the Director of PI is not readily available, the Medical Director or Clinic Administrator should be contacted.

In addition, there are additional IL state laws that require specific patient authorization from the patient to specifically release information on HIV/AIDS, alcohol or drug abuse treatment and mental health treatment. This information can not be released without this authorization.

All staff is accountable for maintaining the privacy of medical records knowing that breaches of confidentiality and/or privacy may be prosecuted. All personnel are to be informed of the confidentiality and privacy policy upon employment at PCC Community Wellness Center or upon completing a contract with PCC Community Wellness Center. Any person or agency that has unsupervised access to the clinic (e.g. cleaning personnel, couriers, security, etc.) are to be given a written notice of the confidentiality and privacy policy and the fact that breaches may be prosecuted.

Minimum Necessary
Minimum necessary is the use of disclosure of the least amount of information required to complete the purpose or function intended. All disclosures of protected health information for the purposes of treatment, payment and healthcare operations will contain only the amount of information necessary to achieve the purpose of the disclosure.

Original: 3/93
Revised: 7/02, 9/02, 2/03, 3/05, 10/05, 8/07, 8/09, 1/11, 10/12

Exhibit A

Exhibits A and B effective June 2011

Yakima Valley Memorial Hospital Confidentiality Agreement

Patient Privacy

The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule created a national standard to protect individuals' personal health information (PHI) and enables patients to have increased access to their medical records.

Any information, whether spoken, electronic or written that relates to the health of the individual, the health care provided to that individual or payment for health care provided is considered protected.

Patients have the right to:

- Know who has accessed his/her health information
- Access his/her medical record
- Request that the Hospital amend information in their record
- Require authorization before information is given, except as allowed by HIPAA
- Request an accounting of all disclosures of the past six-years
- A patient or patient's representative has a right to ask the Hospital to place restrictions on the use and disclosure of the patient's protected health information
- Choose recourse if his/her rights are violated

Your Role in Protecting Patient Rights

No information that relates to a patient's health may be disclosed unless authorized by the patient or patient's representative unless permitted by HIPAA regulation. Yakima Valley Memorial Hospital is obligated to limit access to only those individuals who need the information for a legitimate purpose.

Any information that is shared should be limited to the minimum necessary; the least amount of information to accomplish the purpose of the request is optimal. However, this does not apply to the sharing of the medical record for treatment purposes.

You are accountable for:

- Appropriate disposal of materials containing patient identifiable health information
- Understanding the process for reporting patient and employee concerns regarding privacy
- Understanding the consequences for disclosing confidential patient information

NOTE: Inappropriate access to, or disclosure of patient information can lead to denied access, disciplinary action by your employer and legal action.

Helpful Resources:

If you have questions about these practices, you are urged to contact the people below:

YVMH Privacy Officer: Director of Health Information Management (resource for staff's concerns) 575-8281

YVMH Security Officer: Jim Aberle, Vice President/Chief Information Officer 575-8681

YVMH Privacy Officer: Melanie Gilmore, RN, Patient Representative (resource for patients' concerns) 576-5774

Yakima Neighborhood Health Services

Signature *Clinic Name* *Date*

This signature verifies that I have received education about HIPAA, Patient Rights and my responsibilities in protecting these Patient Rights.

Please print your name here: _____

interfaithHOUSE
Restoring health, rebuilding lives, returning home.

INTERFAITH HOUSE REFERRAL
TUBERCULOSIS TEST VERIFICATION

Due to serving a high-risk population and the fact that our clients will be living in a community setting, it is vital that we have current (**within the past 30 days**) verification of negative tuberculosis status *even if the client is not currently displaying any signs or symptoms of active TB*. Please refer to the following guidelines of what constitutes adequate testing and documentation for admission to our program.

1. PPD placement: A negative PPD test is adequate if it was placed within the past 30 days and was read within 72 hours of placement.

2. Chest X-ray: For clients with positive PPD test results or a history of positive PPD test results, a recent (within the past 30 days) chest x-ray with normal results or showing no signs of tuberculosis is adequate.

3. Three negative sputums: For clients who were treated for active tuberculosis, we require three negative sputum results collected and tested on different days.

Please document the TB testing that was done for the client and **fax in copies of any PPD results, chest x-ray reports, and/or sputum results**.

Client Name: _____ SSN: _____

Location of TB testing: _____
Medical Facility/Organization

PPD placed: ____/____/____ PPD read: ____/____/____ Result: ___ Negative ___ Positive
____ mm induration

Chest x-ray: ____/____/____ Result: ___ Normal/No sign of active TB ___ Abnormal

Sputum results:

Sample One: ____/____/_____ Result: ___Negative ___Positive
Sample Two: ____/____/_____ Result: ___Negative ___Positive
Sample Three: ____/____/_____ Result: ___Negative ___Positive

Please fax to (773) 533-9034

TOPIC: ASSESSMENT AND REASSESSMENT OF PATIENTS

PURPOSE: In order to identify the need for care and treatment of each patient, assessment and reassessment will be performed at the initiation of service and periodically throughout the patient's care as appropriate to the condition of the patient. Assessment, planning, intervention and evaluation are ongoing processes due to the nature of outpatient services.

LEVEL OF RESPONSIBILITY:

Physicians
Advanced Practice Nurses
Registered Nurses

POLICY:

1. Assessments in the Ambulatory Care setting are to be completed by the practitioner based on the chief complaint of the patient (MD, RN, and Nurse Practitioner).

2. The patient's plan of care and treatment decisions, recommendations, and/or referrals are made upon analysis of data collected through the assessment. Such decisions/recommendations/ referrals will be documented in the EMR.

3. Assessments are individualized and appropriate to the age of the patient, neonate through geriatric. Reassessments will be performed to determine efficacy of treatment or to identify additional needs when the patient's condition or diagnosis changes.

PROCEDURE:

Initial Assessment:

1. A practitioner (physician or nurse practitioner) as clinically indicated, will assess all patients for the initial clinic assessment in the ambulatory clinic areas.

2. Initial assessment will include pertinent aspects of the following:
    * patient history interview
    * review of present symptoms
    * assessment of pain
    * assessment of current complaint
    * examination
    * review of systems
    * development of treatment plans

The assessment will be as indicated by the patient's specific needs. The assessment should be completed within the patient's first three visits to PCC.

3. The Medical Assistant performs specific tasks and procedures, including data collection (such as vital signs) as part of the assessment.

4 Ambulatory care nutrition screening may be done as part of the initial assessment, and as condition of the patient warrants.

5. When pain is identified, a more comprehensive assessment is performed when warranted by the patient's condition. Measure of pain intensity and quality (i.e. pain character, frequency, location and duration), appropriate to patient's age are recorded in a way that facilitates regular reassessment and follow-up.

Reassessment:

1. Reassessment will review and evaluate the patient's status of previously identified conditions and evaluate any newly identified conditions.

2. Patients are to be reassessed for pain, functional and nutritional assessment and discharge planning needs as indicated based on previous visit.

3. Age specific expectations will be utilized and documented (e.g. dietary review, smoking status, exercise habits, preventive health maintenance services, etc.).

4. Data will be documented in the patient's EMR.

5. Problem lists and a review of systems will be updated with each patient's visit.

6. Diagnostic testing and/or treatment will be determined by the practitioner utilizing current standards of clinical practice.

7. Follow-up of diagnostic testing will be performed accordingly.

8. Reassessment will be appropriate and indicated by the patient's specific needs. Exclusions to each guideline may exist for each unique clinic, such as for prescription refills, laboratory testing, etc.

Original: 2/96
Revised: 5/02, 5/08, 2/09
Reviewed: 9/14

Example of patient health assessment

mm 54515

* could be a little more inclusive

Self-management
Education provided.

Has skills to manage care.

Reports adherence with medication management.

The following life style modification education provided:
smoking cessation
Other: Went over Hospital discharge intructions with patient and patient understands them. We developed a plan for his stay in respite. Will be working with him and his providers to get better control of his blood sugars, and facilitate specialist appts.

VITAL SIGNS

HEIGHT

Time	ft	In	cm	Last Measured	Height Position	%
12:14 PM	6	3	190.5	04/23/2015		

WEIGHT/BSA/BMI

Time	lb	oz	kg	Context	%	BMI kg/m2	BSA m2
12:14 PM	259		117.48			32.37	

BLOOD PRESSURE

Time	BP mm/Hg	Position	Side	Site	Method	Cuff Size
12:14 PM	120/78	sitting	right		manual	adult

TEMPERATURE/PULSE/RESPIRATION

Time	Temp F	Temp C	Temp Site	Pulse/min	Pattern	Resp/ min
12:14 PM	98.4	36.89	Temporal	80		14

PULSE OXIMETRY/FIO2

Time	Pulse Ox (Rest %)	Pulse Ox (Amb %)	O2 Sat	O2 LPM	Timing	FIO2 %	L/min	Delivery Method
12:14 PM						21		

Interpreter Needed: No

Interpreter:

Primary Language Spoken: English

Place of Service: YNHS-H-Respite

Time In:

Time out:

Demographics

PCP: Rutter, Amelia Rutter, Amelia

Race: White

Ethnicity: Not Hispanic or Lat

Country of Origin: usa

Zip Code: 98901

Homeless Encounter Form

Initial nurse assessment for respite. Went through hospital discharge and compared medications to list we have. Also spent time organizing his routine medications into medi-sets and reviewing his blood sugar values and education as to keeping a log for the Dr. Discusses medical goals for his respite stay as being stabilzation of his blood sugars and healing of his abcesses as well as support of his continued sobriety..

MEDICAL RESPITE CASE MANAGEMENT INDIVIDUALIZED CARE PLAN:

Policy / Purpose

Interfaith House Case Management team works proactively with the participant on his or her individualized care plan; this case management model intended to serve persons with complex medical and/or adherence health-related needs. The care plan is developed with the participant specifying treatments, goals and discharge indicators. The model is designed to serve individuals who may require assistance with access, utilization, retention and adherence to primary health care services. Clients need ongoing support from case management to actively engage in medical care, and continued adherence to treatment.

The case management services are a range of client-centered services that link clients with health care, psychosocial, and other services. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's needs and personal support systems. Case management services will be culturally, and linguistically appropriate to the target populations served. A primary goal of Medical Respite case management is to assist the clients in moving toward empowerment, self-determination, and self-sufficiency. This allows the case manager to transition clients to more appropriate programs and services as the client's medical and psychosocial status improves, freeing beds for people who are most in need: The case management staff conducts an assessment and services; for each participant the assessment includes.

- Date of intake
- Source of referral
- Prior Living Situation and address, phone, emergency contact
- Age/ Date of birth
- Gender / Racial or ethnic identification
- Current diagnoses, pertinent history, medication history, (including allergies and sensitivities), current medications, and any current treatments
- Source of any current medical care
- Documentation of health insurance, (if applicable)
- Any other current or chronic medical condition/ need for care
- Functional status, including communication needs.
- Psychosocial needs, including substance abuse and options for treatments.
- Pain status, as needed.
- Documentation of any current financial income/pay stub
- History of incarceration/parole status
- Signed release of information
- Anticipated discharge needs.
- Evidence the Case Manager explained, and the received the following:
    - — Client rights and responsibilities
    - — Client grievance procedure
    - — Information on confidentiality

CASE MANAGEMENT

POLICY:

Interfaith House Medical Case Management is a proactive case management model intended to serve persons living with multiple complex medical and/or adherence health-related needs. The model is designed to serve individuals who may require assistance with access, utilization, retention and adherence to primary health care services. Medical Case management clients need ongoing support from case management to actively engage in medical care, and continued adherence to treatment.

Medical case management services are a range of client-centered services that link clients with health care, psychosocial, and other services. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's needs and personal support systems. Medical case management services will be culturally, and linguistically appropriate to the target populations served. Medical case management may be delivered face-to-face, via telephone, or utilizing other forms of communication appropriate for the client. A primary goal of Medical case management is to assist the clients in moving toward empowerment, self-determination, and self-sufficiency. This allows the case manager to transition clients to more appropriate programs and services as the client's medical and psychosocial status improves, freeing valuable resources for people who are most in need.

A **"service unit"** of medical case management is defined as a visit or encounter lasting 15 minutes or longer, either face to face or by telephone.

Key activities:

- Intake and eligibility determination
- Assessment and reassessment
- Service Plan development
- Implementing and monitoring the Service Plan
- Coordination
- Adherence Planning
- Active referral and follow up
- Transition and case closure
- Records management
- Case load management

At a minimum, medical case management must include the following;

- Provision of treatment adherence counseling to ensure readiness for, and adherence to, complex treatments.
- Coordination and follow-up of medical treatments
- Client-specific advocacy and/or review of utilization of services
- Motivating and assisting clients to access long-term support for health care costs, including Medicaid, Medicare, COBRA, and pre-existing condition insurance plans.

Implementing and Monitoring

Purpose: The provision of Medical Case Management should be consistent with the Service Plan. Monitoring occurs to ensure that provided services are consistent with an individual Service Plan, and are evaluated. Monitoring is an ongoing data collection process. The frequency of monitoring is dependent on the level and intensity of client need.

Standard: Clients should receive Medical Case Management that is suited to their situation. Medical Case Management should be relevant to the client's current situation, provide active referrals, advocacy and interventions based on the Service Plan, determine the need for treatment plan revision, maintain ongoing client contact, and evaluate the level of client satisfaction.

Criteria: The Service Plan should be consistent with needs identified in the comprehensive client assessment. The strategy or plan of action should be consistent with the updated Service Plan including:

- Assistance in arranging services, making appointments, and confirming service delivery dates;
- Encouragement to client to carry out tasks they agreed to;
- Support to enable clients to overcome barriers and access services;
- Negotiation and advocacy as needed;
- Other case management activities as needed.

Monitoring involves carrying out of tasks listed in the Service Plan, including the following activities:

- Provider contact in person, by phone, or in writing;
- Conducting ongoing monitoring and follow-up with clients and providers to confirm completion of referrals, service acquisition, maintenance of services and adherence to medical care;
- Actively following-up on established goals in the Service Plan to evaluate client progress and determine appropriateness of services;
- Assisting clients in resolving any barriers to completing goals in the Service Plan

Implementing and Monitoring the Service Plan

Purpose:

The focus of the assessment is to evaluate the client's medical and psychosocial needs, strengths, resources, limitations and projected barriers to client-centered services. Information obtained is shared with the participant and their input is documented in the assessment and used to develop the treatment plan and assist in the coordination of a continuum of care.

Policy:

The Service Plan which should be inclusive of all those involved in the patients care; and should also include the frequency of encounters and be consistent with the needs identified in the comprehensive client assessment and/or reassessment. Clinic Providers and Case Managers will revise Service Plans as changes in client circumstances warrant. The case manager should coordinate services between all disciplines assuring that treatment and services provided are shared among all members of the interdisciplinary team. The strategy or plan of action should be consistent with the updated Service Plan including:

- Short-term and long-term goals
- Action steps to address each goal
- Specific services needed and referrals to be made
- Barriers and challenges
- A timeline
- A plan for follow-up each goal

- Assistance in arranging services, making appointments, and confirming service delivery dates;
- Encouragement to client to carry out tasks they agreed to
- Support to enable clients to overcome barriers and access services;
- Negotiation and advocacy as needed

_____ _____

Executive Director Date

Interfaith House
Progress Note

Name: **Room Num:**

Date/Time:	Description

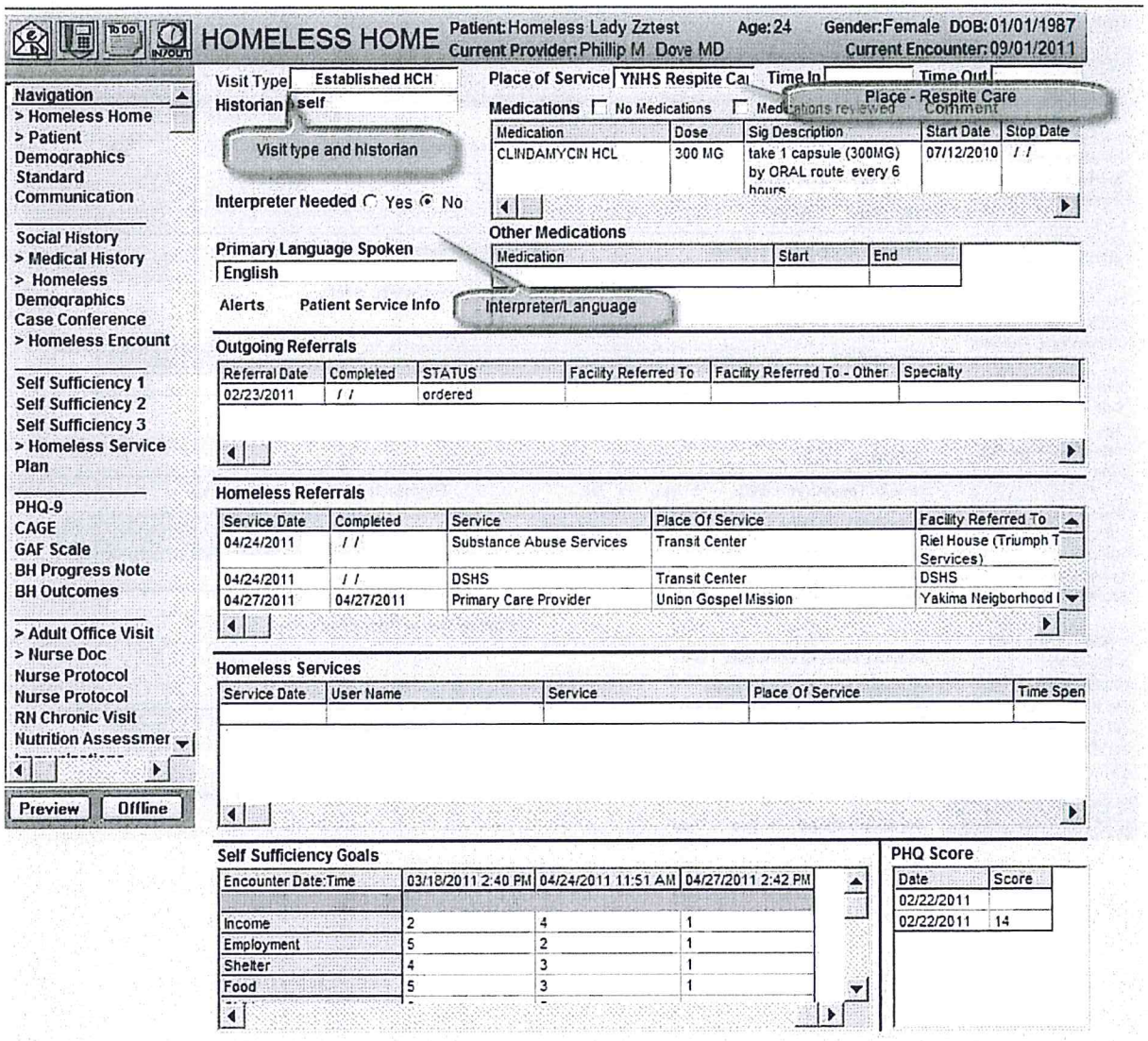
Revised March 2014

Example of reporting and discharge doc.

Reporting on Respite Care through Homeless Templates:

Three templates should be used at each encounter: 1)Homeless Home; 2)Homeless Demographic; 3) Homeless Encounter. The Homeless Services Encounter

1. Use the Homeless Home to open the new encounter and record the visit type (new or established HCH, interpreter needs, and language, time in and out).



Permanent Supportive Housing Inter-disciplinary Caseloads

Project based sites versus Scattered Sites may require lower caseloads .

Rural projects may also require lower caseload due to additional travel time between sites.

- Health Home Patients in PSH
  - 1 : 50
- PSH – Chronically Homeless with Chronic Disabilities
  - 1 : 10
- PSH – High Needs Families
  - 1 : 15
- Respite Care –
  - 1 : 15 (blended team, multi-discipline)

Example of wellness check doc.

Yakima Neighborhood Health Services
12 South 8th St, PO Box 2605
Yakima WA 98907-2605
Phone (509) 454-4143 Fax (509) 454-3651
www.ynhs.org

RESPITE CARE, Staff Check in Room # ____

DATE	TIME	INITIALS	NOTES

Accredited by the Joint Commission on Accreditation of Healthcare Organizations

Coordinating Care

Policy:

Interfaith House provides a structured program in which residents can recover from an illness or an injury; it is their responsibility to follow their medical recovery plan by taking all medications as prescribed, filling prescriptions, and attending all medical appointments/therapy. Altering one's medical recovery plan without consent from a medical provider could lead to serious physical consequences. Therefore, residents should obtain any treatment changes in writing from their medical provider. In addition, residents should not give or share their medications, walking aids, or wheelchairs with other residents.

Procedure:

- Residents will automatically get signed up for the clinic during their orientation period for an intake assessment and physical. Physicians and nurse practitioners are generally available in the Health Services Clinic (Office 207) Monday through Friday. Residents may sign-up to see a clinic provider by writing their name on the list posted on the clinic door or by seeing a case manager for assistance.

- Case management will assist eligible residents with obtaining identification documentation and applying for public benefits such as SSI, SSDI, Medicaid, and Social Security. Residents establishing an income during their stay at Interfaith House are required to participate in the savings program

- Case Managers will work with residents assisting them with scheduling medical appointments, obtaining needed medications and supplies, navigate the health system and assist with establishing a medical home and providing support and education regarding health issues. Residents should take a medical appointment summary form to every medical appointment and turn in copies of all medical papers. Medical Appointment Summary forms can be obtained in office 209,

210 and 212 or at Central Desk. Residents should meet with their case manager on a regular basis for a check-in and to fill a weekly pill organizer (med box). Non-prescription medications, including pain relievers and cold medicine, are available on a limited basis in the medication room.

- Residents will meet with the Substance Abuse Referrals Counselor and Mental Health Case Manager for an assessment during their orientation period. Residents in need of substance abuse treatment or mental health treatment or aftercare will be referred for services at that time. Treatment referrals are part of the service plan and need to be followed.

- To keep medications safe and to ensure compliance, all medications must be turned into Central Desk for storage in the medication room. Creams, lotions, and solutions for dressing changes may be kept in resident rooms. Residents may see their case manager if they would like to keep inhalers, glucose tablets, or nitroglycerin in their possession. If a resident is going to be absent from the building on appointment/pass, they should take their needed medication doses with them. Otherwise, **medications should be taken in the med room**. You are given a **water bottle** upon intake, you should **only fill this bottle with water**, and you should bring it each time when taking medication.

- Interfaith House. Staff will refer and discharge residents to appropriate housing once it have been determined that they are stable to move on in the continuum of care. The average length of stay at Interfaith House is two to three months based on the resident's medical recovery plan.

_____ _____

Executive Director Date

Example of agreement

SERVICES AGREEMENT

THIS SERVICES AGREEMENT ("Agreement") is entered into as of October 1, 2013, by and between PCC Community Wellness Center, an Illinois not-for-profit corporation having an office at 14 Lake Street, Oak Park, Illinois ("PCC") and Interfaith House, an Illinois not-for-profit corporation having an office at 3456 West Franklin Boulevard, Chicago, Illinois ("INTERFAITH HOUSE"). PCC and INTERFAITH HOUSE are sometimes referred to herein collectively as the "Parties" and individually as a "Party."

RECITALS

INTERFAITH HOUSE provides respite care and supportive services for ill or injured homeless adults.

PCC is a federally qualified health center that provides medical services to Chicago's Austin neighborhood.

INTERFAITH HOUSE desires to engage PCC to provide contract physician services at INTERFAITH HOUSE.

It is agreed as follows:

1. **Services**

   a. PCC will offer physician services on-site at INTERFAITH HOUSE four clinic sessions per week. The days and times of such clinic sessions shall be mutually agreed upon by the parties. Comprehensive primary care services will be offered, including:
      i. Preventive care (such as well-woman care, cancer and chronic disease screening, and administration of vaccines obtained by INTERFAITH HOUSE)
      ii. Care of chronic illness
      iii. Care of acute illness
      iv. Certain diagnostic testing, including phlebotomy, urinalysis, pregnancy testing, PPD testing, microscopy, STD screening, and Pap smears
      v. Minor office procedures
   b. PCC physicians will perform intake assessments on new INTERFAITH HOUSE residents to determine the resident's connection to primary care. If the resident does not have a primary care provider, the PCC physician will assume this responsibility. If the resident is already engaged in a primary care relationship, the PCC physician will encourage (and facilitate, when necessary) continuation of that relationship.
   c. At the request of INTERFAITH HOUSE staff, PCC physicians will assess residents' medical stability for discharge from INTERFAITH HOUSE.
   d. When a provider is not available at INTERFAITH HOUSE for an acute health care need, PCC will offer care at one of its sites. If PCC centers are closed, INTERFAITH HOUSE staff may contact PCC's on-call physician for health care advice.
   e. PCC physicians will coordinate medical services with other health care providers contracted by INTERFAITH HOUSE.
   f. PCC will maintain a current medical record for each of its patients.

g. PCC physicians will assist INTERFAITH HOUSE staff in assuring continued primary medical care after discharge, either at PCC or at another health center.

2. **Medical Direction**

PCC will provide the medical direction of the clinic. PCC will be responsible for maintaining an appropriate system of quality controls over all operations. PCC will provide INTERFAITH HOUSE with a copy of its standards, and with a copy of the results on request by INTERFAITH HOUSE. PCC agrees to assume all responsibility for monitoring the medical care provided.

3. **Indemnification**

INTERFAITH HOUSE shall indemnify and hold PCC harmless from and against any and all claims, liabilities, and/or damages arising from the utilization of the physical space at INTERFAITH HOUSE, including costs of litigation and counsel fees. PCC shall indemnify and hold INTERFAITH HOUSE harmless from and against any and all claims, liabilities, and/or damages arising from the provision of services described in Section 1 above and the medical direction provided in Section 2 above, including the costs of litigation and counsel fees.

4. **Insurance**

PCC shall maintain coverage for professional liability of PCC, its agents and employees under the Federal Tort Claims Act ("FTCA") in an amount not less than $1,000,000 per claim and $3,000,000 in the annual aggregate. PCC shall also carry such other insurance as shall be necessary to insure PCC, its agents and employees, against any and all damages arising from PCC's various duties and obligations. INTERFAITH HOUSE shall obtain and maintain proof of professional and general liability insurance with limits not less than $1,000,000 per person per claim and $3,000,000 annual aggregate. All insurance described herein above shall remain in effect so long as this Agreement remains in effect. Each party shall provide the other party with a copy of the policy (or policies) evidencing the foregoing requirements upon request.

5. **Meetings**

PCC will organize a quarterly meeting to review Clinic operations, to include all Clinic providers and INTERFAITH HOUSE representatives as chosen by INTERFAITH HOUSE.

6. **Non-Exclusive Arrangement**

PCC understands that this arrangement is not exclusive and in no way restricts the ability of INTERFAITH HOUSE to accept referrals or work cooperatively with other providers of medical care. PCC also acknowledges that this cooperative working arrangement carries no expectation of referral after discharge and that residents with existing primary care relationships will be encouraged to maintain those relationships during their stay at INTERFAITH HOUSE and after discharge.

ON BACK Example of medical record system

7. **Mutuality**

This agreement is mutually acceptable and mission consistent for both organizations. It allows INTERFAITH HOUSE to better serve the medical needs of the adult homeless population, and it offers PCC an opportunity to extend the medical services they provide to underserved patients.

8. **Retention of Rights**

INTERFAITH HOUSE staff will retain all responsibility for decisions about accepting new residents and make final determinations about discharges. In addition, all decisions about referrals to PCC or other providers of medical care will be made by INTERFAITH HOUSE staff.

9. **Term and Termination**

a. The initial term of this Agreement shall be for one (1) year, beginning on October 1, 2013 and terminating on September 30, 2014. Thereafter, this Agreement shall automatically renew for one-year terms unless terminated as provided herein.
b. Either Party may terminate this Agreement, with or without cause, by providing ninety (90) days prior written notice to the other Party.
c. This Agreement shall automatically terminate if either Party fails to maintain in good standing its licensure, certification or accreditation governing the operation of its facility. Such Party shall immediately inform the other Party in writing of such failure.
d. Either Party may terminate this Agreement, or any portion hereof, in the event the Agreement, or such part hereof, is deemed to be contrary to local, state, or federal law and it cannot be modified or amended in a way that is mutually agreeable to the Parties and complies with applicable law. The Parties agree to use their best efforts to modify the Agreement consistent with applicable law and to make changes to the minimum extent necessary to try to retain as closely as possible the original economic and other terms, as are reflected in this Agreement.

IN WITNESS WHEREOF, the Parties hereto have executed this Services Agreement on the day and year first written above.

INTERFAITH HOUSE

By: _____
Jennifer J. Nelson-Seals
Executive Director

PCC COMMUNITY WELLNESS CENTER

By: _____
Robert J. Urso
President and CEO

Yakima Neighborhood Health Services
12 South 8th St, PO Box 2605
Yakima WA 98907-2605
Phone (509) 454-4143 Fax (509) 454-3651
www.ynhs.org

Housing and Respite Stability Plan

Name of Participant _____ Date _____

Name of Outreach Specialist _____

This form is to aid the participant in achieving their specific personal goals and objectives and developing a plan of action that will help transition the participant to stable housing, self sufficiency and fulfillment of their personal hopes. It is to be filled out by the Participant with the help of the Outreach Specialist.

Short term objective required by the Program

Objective	Plan of Action
Financial Literacy Training / Income Review	

Program goals and performance measures
(Consider goals such as: Improving health condition, obtaining health insurance, finding medical provider, finding safe long-term housing , etc.

Category	Short Term Goals	Action Plan including Steps/Barriers, Time Frame/who is responsible	Expected Completion Date
1.			
2.			
3.			

Identify at least one personal long term goal which participant hopes to accomplish in the next few years.

Long Term Goal	Action Plan

Client Signature:
_____Date:_____
Staff Signature:
_____Date:_____

Accredited by the Joint Commission

EX. **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

Resident Life Services - Transportation

Policy

Interfaith House attempts to provide wheelchair accessible transportation for those residents not able to use public transportation. The Interfaith House bus drops off and picks up residents at medical and social services appointments. Residents are limited to one drop-off and pick-up each day. Transit cards are provided for residents that are able to self -transport.

Procedure

1. Each evening (Sun.-Thurs), Resident Life Services staff announces the last call for appointment listing, at which time all residents with appointments the following day should come to Central Desk to write their appointment on the sheet. Residents approved for use of Interfaith House transportation services should be ready by 8:15 a.m. to depart with the Transportation Coordinator.
2. All residents able to transport themselves using public transportation should obtain fare cards on the day of their appointment at 7:30am from the transportation coordinator. No residents will be given fare cards without written documentation of an appointment.
3. Each morning the Transportation Coordinator reviews the *Transportation List* and sets a drop-off plan.
4. Residents are dropped off at their appointments and must call Interfaith House to be picked up. Central Desk calls the driver to make the pick-up.
5. Transportation is available for emergency situations if 911 is not required.

_____ _____

Jennifer Seals, Executive Director Date

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_____ _____

Jennifer Seals, Executive Director Date

Resident Services – Transportation Assistance

Policy

In order to promote successful completion of our program, Interfaith House will provide transportation assistance to residents for appointments and other staff approved business. Residents will not be transported by the Transportation Coordinator to go to currency exchanges or to go shopping. Transportation assistance can be provided by vehicle or Chicago Transit Authority fare cards as appropriate and available. Transportation services by Interfaith House vehicle are generally available from 8:15am to 4:00pm on business days for appointments. Residents that have multiple appointments or appointments that fall outside of the boundaries require a Special Transportation Request. Any staff person transporting a resident is responsible for obeying all traffic regulations and will be responsible for any traffic tickets not related to vehicle maintenance.

General Transportation Procedure:

1. Residents that have appointments are responsible for signing the appointment sheet by 10:00pm the night before. Residents are responsible for seeing their case manager if their transportation need requires a special request.
2. Night time RCA's will create a draft transportation list for the next day.
3. The Transportation Coordinator will review the transportation list and make changes as appropriate to optimize transportation resources.
4. The Transportation Coordinator will do a transit card call at 7:30am on weekday mornings. Residents are required to show written proof of appointment to receive transit cards. Exceptions may be made at the Transportation Coordinator's discretion.
5. The first transportation departure is scheduled for 8:15am. The Transportation Coordinator will page residents on the transportation list starting at 8:00am. Subsequent transportation departures will be made as the schedule dictates.
6. Residents will be given the Interfaith House phone number so they can call when they are ready for pick-up. Residents will be informed that they will be picked up in the same location they were dropped off.
7. Residents that miss the transportation call will only be taken to their appointment as transportation resources are available. Residents will be directed to see their case manager to follow-up with rescheduling missed appointments.
8. RCA staff will keep a list at Central Desk of those that have called for a pick-up. The Transportation Coordinator will have a cellular phone by which s/he may be contacted for information regarding pick-ups and last minute special requests.
9. When the Transportation Coordinator is called for a pick-up, s/he will go to the place the resident was dropped off and look for the resident. If the resident fails to come out, the Transportation Coordinator will use his his/her best judgment on finding a safe spot near the pick-up location to wait. The Transportation Coordinator will only wait up to ten minutes.
10. As funding is available, Interfaith House will have a part-time Transportation Coordinator whose main responsibility will be to transport residents to substance abuse treatment/appointments. The part-time Transportation Coordinator may be used to transport residents to other appointments as available.
11. Whenever possible, the Transportation Coordinator that dropped off the resident should pick up that resident. Other pick-up arrangements may be made as appropriate so long as communication is occurring between the Transportation Coordinators and Resident Life Manager. At the end of his/her shift, the Transportation Coordinator will contact the

Program Staff on duty to notify him/her about residents still out at appointments that may need pick-up.

12. Staff should contact the Resident Life Manager for unexpected, same-day transportation requests. If the Resident Life Manager is unavailable, staff may contact any other Program Manager or the Program Director for Assistance. If the Transportation Coordinator has a concern about being able to meet a Program Managers' request, s/he may contact the Program Director. The Transportation Coordinator should add any approved same-day requests to the van list at Central Desk.
13. Program Staff will have access to fare cards for last minute resident appointments.
14. The Resident Life Manager is responsible for monitoring the transit card supply and distribution.

Special Transportation Assistance Procedure:

1. Residents that have an appointment requiring a special transportation request (see above) are responsible for notifying their case manager. If their case manager is unavailable they should see another program staff.
2. Staff should complete the Special Transportation Request form and submit it at least two business days in advance. The original should be submitted to the Resident Life Manager and a copy to the Transportation Coordinator.
3. If a Special Transportation Request cannot be submitted at least two business days in advance, staff may still complete and submit the request. Staff should also contact the Resident Life Manager about the request.
4. The Resident Life Manager will review the request. If resources are available, the Resident Life Manager will list the special request on a calendar located at Central Desk. If resources aren't available, the Resident Life Manager will inform the staff submitting the request.

_____ _____

Executive Director Date

Resident Life Services

Daily Activities
Bed Rest

Policy: Interfaith House provides a structured daily schedule as part of the Resident Life program. The schedule includes educational, optional spiritual and daily activity opportunities. Residents can leave Interfaith House during scheduled hours each day. One weekday afternoon is designated Resident Free Time so staff can be available for weekly program meetings. In order to promote active participation in the scheduled activities, residents are not to return to their bed during the daytime schedule except during afternoon free time period or when they are on bedrest for medical reasons.

Procedure:

- Afternoon free time is from 12:30 to 3:00 p.m. on Monday, Tuesday, and Thursday; On Wednesday and Friday free time is from 12:30 to 5:00 p.m.
- Residents must be in bed by the scheduled time, but may go to bed early after the last scheduled evening activity.
- Exceptions to this policy when residents are on bed rest which is usually approved by the Health Services Department, Case Managers, and Managers for residents who are sick and by the Supervisor of Resident Life for residents who work during the night.
- Rounds are made hourly by the Resident life staff and any changes in the resident's condition is communicated in the log and to the health services and clinic staff.

_____ _____

Executive Director Date

wesley Health Centers

You ARE INVITED...

April 7, 2015

S3: C-1
Click here to return to Standards Page

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.

Services fliers

All Under ONE Roof!

SERVICES AVAILABLE AT The Depot

- Homeless Prevention Assistance
- Transitional and Permanent Supportive Housing
- Medical Respite Care for the Homeless
- Transportation Assistance
- Self Sufficiency Help
- Health Care for the Homeless Care Coordination (Medical / Dental / Behavioral Health)
- Connection to Employment and Training
- Health Insurance Applications (Washington Apple Health / Washington Healthplanfinder
- Application Assistance
- Basic Needs & Hygiene Items
- Housing and Essential Needs (HEN)

not enough?

Y · A · K · I · M · A Neighborhood HEALTH

Yakima:
602 East Yakima Ave.
(509) 249-6232

Sunnyside:
617 Scoon Road
(509) 837-8200

Homeless Network of Yakima County
Working for the Homeless. Because we Care.

washington healthplanfinder

Part of care plan and possibly exit placement options

Yakima Neighborhood Health Services
12 South 8th St, PO Box 2605
Yakima WA 98907-2605
Phone (509) 454-4143 Fax (509) 454-3651
www.ynhs.org

Housing Stability Plan

Name of Participant _____ Date _____

Name of Outreach Specialist _____
This form is to aid the participant in achieving their specific personal goals and objectives and developing a plan of action that will help transition the participant to stable housing, self sufficiency and fulfillment of their personal hopes. It is to be filled out by the Participant with the help of the Outreach Specialist.

Short term objective required by the Program

Objective	Plan of Action
Financial Literacy Training through Consumer Credit Counseling /Landlord tenant agreement	

Program goals and performance measures

Category	Short Term Goals	Action Plan including Steps/Barriers, Time Frame/who is responsible	Expected Completion Date
1.			
2.			
3.			

Identify at least one personal long term goal which participant hopes to accomplish in the next few years.

Long Term Goal	Action Plan

Client Signature:
_____ Date: _____

Staff Signature:
_____ Date: _____

Revised 07/14/2010

Example

Program Administration – Resident Discharges

Policy

Interfaith House strives to find appropriate discharge placement for its residents. Interfaith House will not discharge any resident unless an appropriate placement has been found for him/her. Residents that are AWP (Absent Without Permission) relinquish their rights and privileges as a resident of Interfaith House. Residents may be involuntarily discharged without 24 hour notice by a Manager with consultation with Program Director or Associate Program Director for theft, intentionally destroying agency or other resident's property, engaging in physical violence or abuse, possession of weapons, using, selling or having alcohol or illegal substances on Interfaith House property, multiple substance abuse relapses, or failure to abide by policies and procedures. If a resident disagrees with the decision to be discharged, for any reason, the resident should utilize the grievance procedure.

Procedure for Planned Discharges:

1. The resident's Case Manager should notify Central Desk in writing about the discharge.
1. The resident will be given a discharge letter informing him/her about the procedures regarding mail, valuables, medications, storage for personal belongings, aftercare and other matters..
2. It is the responsibility of the Central Desk staff member who began the discharge procedure to ensure that the process is completed appropriately and thoroughly as indicated on the discharge checklist.
3. The resident should be given the opportunity to complete a Discharge Questionnaire.
4. Housekeeping is made aware of the discharge so the bed and area can be cleaned.

Procedure for AWP Discharges:

1. Residents who do not return to the building before curfew are considered absent without permission and should be discharged by 5:00pm the following business day or by 12:00pm on the first business day following a weekend or holiday pass **if they have not called to state their whereabouts or intentions in regards to housing.**
2. The resident's Case Manager should notify Central Desk in writing about the discharge.
3. It is the responsibility of the Central Desk staff member who began the discharge procedure to ensure that the process is completed appropriately and thoroughly as indicated on the discharge checklist.
4. Housekeeping is responsible for cleaning the bed area.

Procedure for Self Discharges:

1. If a resident informs staff that they are self discharging, the resident's case manager should be notified. If the case manager is unavailable, another program staff in the building should be contacted.
2. The resident will be given a discharge letter informing him/her about the procedures regarding mail, valuables, medications, storage for personal belongings, aftercare and other matters.
3. The resident should not be formally discharged until their case manager notifies Central Desk in writing about the discharge.
4. Upon receipt of the written notice of discharge, it is the responsibility of the Central Desk staff member who began the discharge procedure to ensure that the process is completed appropriately and thoroughly as indicated on the discharge checklist.
5. The resident should be given the opportunity to complete a Discharge Questionnaire.

2/3/7

6. Housekeeping made aware of the discharge so the bed and area can be cleaned.

Procedure for Emergency Discharges due to Violence:

1. If a resident becomes physically violent, 911 Emergency Personnel should be called
2. As soon as it is possible and safe, request assistance from additional staff.
3. If possible, isolate the resident from the rest of the community.
4. All attempts should be made to follow standard discharge procedures, making a special effort to return medications to the departing resident. The resident should not be formally discharged until their case manager notifies Central Desk in writing about the discharge.
5. Upon receipt of the written notice of discharge, it is the responsibility of the Central Desk staff member who began the discharge procedure to ensure that the process is completed appropriately and thoroughly as indicated on the discharge checklist.
5. Housekeeping is made aware of the discharge so the bed and area can be cleaned.

Procedure for Due Process for Involuntary Discharges:

1. A written notice, containing a clear statement of reason(s) for discharge, shall be given to the residents upon departure. Typical reasons for involuntary discharge are :
    a. Sabotaging Housing Placements/Refusing Housing Placements
    b. Repeated rules and/or Policy violations
    c. Non –Compliance with medical recovery.

   Residents will also be provided another copy of the Grievance Procedure.
2. Should the resident disagree with the discharge decision he/she should utilize the Grievance Procedure
3. The final outcome of the Grievance Procedure will be considered the final decision regarding the discharge.
4. Any resident continuing to disregard the discharge placement or who refuses to leave Interfaith House will be escorted off the premises by authorities.
5. The resident's Case Manager should notify Central Desk in writing about the discharge.
6. It is the responsibility of the Central Desk staff member who began the discharge procedure to ensure that the process is completed appropriately and thoroughly as indicated on the discharge checklist.
7. Housekeeping is made aware of the discharge so the bed and area can be cleaned.

_____ _____

Executive Director Date

Ex discharge form

INTERFAITH HOUSE

Restoring Health, Rebuilding Lives, Returning Home

Name: _____ Date: _____

Before you depart from Interfaith House, it is important that you are aware of the following policies regarding your discharge and your belongings:

Mail You must inform all parties from whom you expect to receive mail of your new address. Residents' mail will be held for 7 days after it arrives. Any mail received after these times will be returned to sender.

Valuables Any money or valuables you have deposited into the safe must be retrieved during banking hours on Monday, Wednesday, and Friday from 2:30 p.m. – 3:00 p.m. Valuables will be kept for up to 6 months.

Medical A copy of your medication list can be provided for you including any refill information: please continue your care with your Primary Care Doctor. Any medication that is left at Interfaith House will be held for 2 weeks. As with all belongings (except for items left in the safe), ***Interfaith House will not be held responsible for items left behind by the resident.*** *Please follow-up with* PCC Wellness Center at (773) 378-3347 if you have questions related to your medical issues or need further assistance with arranging primary care follow-up

Storage You are asked to take any personal belongings with you upon discharge. Anything left will be stored at Interfaith House for ONE WEEK. You may claim your belongings Monday – Friday between 9 a.m. and 5 p.m. ONLY. Any unclaimed items will be discarded after 7 DAYS.

Questionnaire You are asked to fill out a discharge questionnaire that you will receive from your case manager. Return the form to the case manager or Central Desk.

Return Visits/Volunteering Once you have left Interfaith House, you may not return for 6 months unless you need to pick up mail/documents/belongings, or if you have an appointment with a staff member. If you would like to return to visit before then, please complete an *Alumni Request to Return* form (which can be obtained from Central Desk). Residents are encouraged to discuss follow-up medical care and other services (case management, financial affairs, AA/NA meetings, etc.) with their case managers.

In addition, you may be contacted by our Housing Outreach Coordinator to help support you in any issues you may have regarding housing and other psychosocial services.

○ SELF DISCHARGE

○ PLANNED DISCHARGE/AFTERCARE PLAN

Location: _____

Address: _____

Phone Number: _____ Contact Person: _____

Resident Signature: _____ Date: _____

Staff Signature: _____ Date: _____

Follow-up medical appointment and physician contact: _____

_____

Follow-up psychiatric appointment and contact person: _____

_____

Interfaith House Collaborative Health Partners
Medical Stability and Discharge Assessment

Client Name: _____ DOB:_____ Case Manager:_____

Discharge Desination (Name/Type):_____

Location: North South East West Suburbs Unknown Other

Dates Referred for Assessment:_____ Tentative Discharge Date:_____

Admitting Conditions: _____

Conditions Stabilized: Yes No Comments: _____

Physical Assessment: with little difficulty can the client

1. Climb Stairs: Yes No Comments: _____
2. Take public transportation: Yes No Comments:_____
3. Perform light work: Yes No Comments: _____

Future Appointments

Specialists: _____

Scheduled Surgeries/Procedures: _____

Mental Health: _____

Primary Care (date, time, clinic name and location, doctor): _____
Circle below

PCC Austin Family Health Center
5425 W. Lake St.
Chicago, IL 60644
773-378-3347

PCC at Loretto Hospital
645 S Central Ave, Suite 600
Chicago, IL 60644
773-537-0020

PCC Lake Street Family Health Center
14 Lake St.
Oak Park, IL 60302
708-383-0113

PCC Melrose Park Family Health Center
1111 Superior St., Suite 101
Melrose Park, IL 60160
708-406-3040

PCC Salud Family Health Center
5359 W. Fullerton Ave
Chicago, IL 60639
773-836-2785

PCC West Town Family Health Center
1044 North Mozart St., Suite 100
Chicago, IL 60622
773-292-8300

PCC South Family Health Center
6201 W. Roosevelt Rd
Berwyn, IL 60402
708-386-0845

Thomas Huggett, MD Family Practice
Breakthrough Clinic
Lawndale Christian
3219 W Carroll Ave
Chicago, IL 60624
872-588-3580, please ask for Jacqueline Alaniz, Referral Coordinator

Discharge Assessment (prior to leaving): Attach Clinical Summary at client's last visit

Goals needed to be met after discharge: _____

PCP appointment made: Yes No Any pending labs: Yes No

Any issues/concerns prior to discharge: _____

_____

Clinician Signature: _____ Date: _____

YAKIMA NEIGHBORHOOD HEALTH SERVICES
Workplace Violence Prevention (WVP) Program

Management Commitment and Employee Involvement

Yakima Neighborhood Health Services (YNHS) is committed to our employees' safety and health. YNHS will not tolerate violence in the workplace and should make every effort to prevent violent incidents from occurring. Management Team and employees will work together to address workplace violence issues.
YNHS employees are responsible for implementing and maintaining our WVP Program. YNHS requires prompt and accurate reporting of all violent incidents whether or not physical injury has occurred. Any incident of violence or threat of violence is to be reported directly to an Administrator as well as recorded on an Incident Report.
YNHS will not discriminate against victims of workplace violence.

Security Measures:

YNHS employees are responsible for using safe work practices, following procedures and assisting in maintaining a safe and secure work environment.

Employees should not engage in verbal threats or physical actions, which might create a security hazard.

Employees should know the emergency codes. Always state your location when using codes. Use the emergency paging option when available.

"Code pink to 'location' " – employee needs help, coworkers should go to the area for a show of force.

"Code pink to all exits in 'building or area' "—secure building, lock down, await further announcements.

"Code Silver in 'location' " – evacuate away from the stated location. Buildings not involved should lock down and monitor entrances to allow evacuated employees to enter. Assess the situation and call for police assistance as appropriate.

Employees should maintain all security locked doors except as noted:

When loading/unloading heavy or bulky items requiring use of a dead bolt or unlocking of a safety lock for brief periods of time. An unlocked security door needs to be monitored by staff at all times.

Safety measures should be used when entering and exiting the workplace.

Each employee is issued an Employee's Entrance key as part of orientation. The key should only be used by employees. If the key is lost or stolen it should be reported to a supervisor and an incident report completed. Upon the completion of employment the key should be returned to a supervisor or other designated staff.

Adequate lighting should be provided.

TOPIC: COMPLIANCE, CONDUCTING INTERNAL AUDITS

PURPOSE: PCC Community Wellness Center will periodically conduct self-audits to determine whether it is operating in compliance with legal, regulatory, and other applicable requirements, as well as with its written standards and policies and procedures and to assess the effectiveness of its Compliance Program.

LEVEL OF RESPONSIBILITIES: Corporate Compliance Officer

POLICY: As part of its efforts to implement an effective Compliance Program, PCC Community Wellness Center will periodically conduct self-audits of its operation, including its coding and billing practices and its written policies and procedures, to ascertain problems and weaknesses in its operations and to measure the effectiveness of its Compliance Program.

PROCEDURE:

1. The Compliance Officer will designate members of PCC's Compliance Committee, clinical, and administrative staff, and/or will retain outside auditing personnel to conduct periodic self-audits of its day-to-day operations, focusing their audits on PCC's risk areas. Persons conducting the audits should have knowledge of the laws, regulations, and other requirements pertaining to the audited practices and be familiar with their application. Audits should be adequately staffed to ensure accurate and complete results. Self-audits conducted by Health Center will include, but not be limited to, a review of the following areas:
   - Coding and billing;
   - Written policies and procedures;
   - Compliance Program; and
   - Other clinical and/or business practice areas that merit concern as identified by the Compliance Officer based on guidance from, the Department of Health and Human Services, Office of Inspection General, and/or other Federal and/or State regulatory and enforcement agencies, prior audits, accreditation reviews, and other assessments.

2. Self-audits will be conducted at least once each year under the direction of the Corporate Compliance Officer.

3. Designated auditor(s) conducting a self-audit pursuant to this policy and procedure will, at the time of the audit, prepare written documentation of the audit activities performed, including the area being audited; the purpose of the audit; the audit start and end date; the persons conducting the audit; the selected audit methodology; the sample size; the results of the audit; and, recommended corrective/preventive action, if any.

4. Designated auditor(s) will report their audit findings to the Compliance Officer.

5. The Compliance Officer, with the assistance of the audit staff, will oversee and, as appropriate, participate in the audit functions performed pursuant to this policy and procedure and, for each such audit, will promptly review the audit results. The Compliance Officer will determine any follow-up needed. The Compliance Officer will prepare a report for PCC's CEO and the PI and Compliance Committee of the Board on the audit's findings and on the status of any follow-up corrective and/or preventive measures.

Original: 2/13

Example of review process

TOPIC: Peer Review Plan

PURPOSE: To unify the diagnostic and treatment approaches of the provider staff and to provide an opportunity for continuous quality improvement.

LEVEL OF RESPONSIBILITY:
All Providers

PROCEDURE:

1. Charts will randomly be selected for review on a periodic basis (at least quarterly).
2. Every provider will be responsible for reviewing 50 charts in a year, with a maximum of 15 per quarter.
3. Reviews will be completed with reports due to the Performance Improvement Department by the last day of each quarter. Providers will look back at least 6 months/1 year of office visits when performing review
4. Each provider will be reviewed by a provider in their own specialty or by their own level of training *(FM to FM, APN to APN, dentist to dentist, LCSW to LCSW)*
5. Areas of review will be based on pre-determined guidelines and health care plan indicators. This will be reevaluated by the provider staff on an annual basis
6. Summary of Peer Review will be given to providers on quarterly basis. Medical Director of PI will present to Steering Committee analysis of Peer Review. Will discuss with Site Medical Directors any providers with areas of concern.
7. Anticipate 15 minutes per chart review or 4 hours per month.

Orig: 12/4/13
Revised: 4/14/15

example of grievance policy

Yakima Neighborhood Health Services
12 South 8th St, PO Box 2605
Yakima WA 98907-2605
Phone (509) 454-4143 Fax (509) 454-3651
www.ynhs.org

Standard 7.2, 7.5

YNHS Health Care for the Homeless / Housing – Appeal Process

If a tenant/family has a conflict with YNHS operations staff or support staff, or feels he/she/they are being unfairly treated, the following process has been developed:

GRIEVANCE PROCEDURES

STEP 1. Whenever possible, try to talk things over with your Case Manager or the Housing Manager directly – the person you are having the conflict with.

STEP 2. If the matter cannot be resolved between the tenant and the staff member directly, the client/tenant should contact the employee's direct supervisor in writing within five days of the incident/issue being contested.

STEP 3. If the matter cannot be resolved by the employees direct supervisor, the issue should be reported to a YNHS Administrator, in writing within the next five working days.

STEP 4. If there are still questions about the matter, submit them in writing to the President/Chief Executive Officer. The President/Chief Executive Officer will review the case and respond in writing to the employee within 10 days.

STEP 5. Any matter that cannot be resolved by step 4 will be referred to the Executive Committee of the Board of Directors for review and decision. The Executive committee may respond to the employee in writing within thirty days.

_____ _____

Received by Tenant date

(1 copy for client / tenant, 1 copy to file)

Example

Resident Life Services - Grievances

Policy

It is Interfaith House's policy to recognize that from time to time it may be necessary for residents to express and seek resolution of service-related grievances or rights violations. Interfaith House provides the opportunity through the following grievance procedure. All residents are guaranteed free access to this procedure. Residents are made aware that such a grievance procedure exists during orientation. No resident will be discriminated against for expressing a grievance. However, this policy does not protect residents from consequences of any rule violations that led up to the grievance. Any discussion that takes place during the resolution of the grievance is strictly confidential.

Procedure

1. A resident may obtain a *Resident Grievance Form* from any program staff member. The resident should complete the first part of the form by stating, in writing, which right was violated and the resolution that is being sought. The resident should submit the form to his/her case manager or an immediate supervisor if a staff member is involved.
2. After receiving the completed *Resident Grievance Form*, the appropriate staff member will conduct a prompt investigation about the incident. That staff member will respond to the resident in writing about the matter within three (3) working days.
3. After receiving the written response, the staff member addressing the grievance will hold a meeting with all involved parties. The meeting will take place within three (3) working days of the investigation's completion.
4. If the resident does not feel a satisfactory resolution has been reached, he/she may re-submit the grievance to the next level supervisor. This supervisor will respond in writing within five working days. Copies of his/her response will also be given to all involved staff members. The decision of the next level supervisor regarding the grievance is final.
5. If a resident does not reach a satisfactory resolution by following this procedure, or if he/she is not comfortable filing a grievance directly with Interfaith House, a grievance may be filed with the Client Grievance Project. The resident may utilize the Client Grievance Project at any step during the procedure outlined above. The Client Grievance Project will act as a mediator between the resident and Interfaith House. The Client Grievance Project can be contacted at 312-747-9646.

_____ _____

Michael Cook, Executive Director Date

INTERFAITH HOUSE
RESIDENT GRIEVANCE PROCEDURE

You are entitled to a fair hearing, If you feel that you have been unfairly discharged and/ or you feel your rights have been violated during the course of the discharge. A non-exclusive list of conduct that may lead to involuntary discharge are: theft, intentionally destroying agency or other client's property; engaging physical violence and or abuse; possessions of weapons; using alcohol or having illegal substances on property; failure to abide by policies and procedures: If behaviors are threatening to the health, safety and well being of the agency it is the sole absolute discretion of Interfaith House to dispense with the informal hearing.

1. Obtain a resident's grievance form from any staff member. Complete the first part of the form by stating in writing which right was violated and the resolution you seek. Submit the form to your case manager or an immediate supervisor if a staff member was involved.
2. After receiving the completed Resident Grievance Form, the appropriate staff member will conduct a prompt investigation about the incident. He/she will respond to you in writing about the matter within three working days.
3. After receiving the written response, the staff member who addressed the grievance will hold a meeting with all involved parties. This meeting will take place within three working days of the investigation's completion.
    a. You have the right to review your file
    b. Confront opposing witnesses
    c. Present testimonies
    d. You may have representation at this meeting.
4. A decision will be determined based and communicated to you by the Program Director.
5. If you feel a satisfactory resolution has not been reached, you may re-submit the grievance to the Executive Director. The Executive Director will respond to you in writing within five working days. Copies of his/her response will also be given to all involved staff members. The decision of the Executive Director is final.

All involved parties will treat all transactions occurring during the grievance procedure confidentially.

Interfaith House Grievance Officer: Pamela Kerr, MSW Programs Director

If you do not reach a satisfactory resolution by following this procedure, or if you are not comfortable filing a grievance directly with Interfaith House, you may also file a grievance with the Resident Grievance Project. You may file a grievance with the Resident Grievance Project at any step during the procedure outlined above. The Resident Grievance Project will act as a mediator between you and Interfaith House. You can contact the Resident Grievance Project at (312) 747-9646.

By signing below, I am recognizing that I completed orientation, understand the conditions of residency, and received and was informed of the Resident Grievance Procedure.

_____	_____	____/____/_____
Resident Name (printed)	Resident Signature	Date

Revised March 2014

Example incident report doc.

INTERFAITH HOUSE
RESIDENT INCIDENT REPORT

Please complete this form and give to the Operations Director within 6 days of the incident. This is required to comply with public law 91-596 and OSHA requirements.

Person completing the report

_____ _____ _____
Name Job Title Date of report

Resident information

_____ Female Male
Name (First, Middle, and Last)

_____
Date of birth

Facts of Accident/Illness

Date of incident ____/____/____

_____Illness _____Injury Did fatality occur? Yes No

Did incident occur on Interfaith House premises? Yes No

Where on the premises did the incident occur?_____

If not on Interfaith House premises, where did the incident occur? _____

_____

Describe the circumstances of the accident or illness (including location, timeframe, actions taken, and witnesses to the incident)

_____

_____

_____

_____

_____

_____ _____
Staff signature Witness signature

Excerpted from the Safety and Emergency Management Guide

Standard 7.2, 7.6

YAKIMA NEIGHBORHOOD HEALTH SERVICES
Unusual Events Reporting Procedure

Preamble:
One of the most important components of an effective risk management program is an unusual events reporting system. This procedure is intended to establish procedures that improve the quality of client care, to define unusual events, to assure unusual events are reported in a timely and accurate manner to the appropriate people, and to assure corrective actions are taken to avoid recurrence.

Procedure:
The Unusual Events and Reporting Procedure is designed to provide a mechanism for the prompt reporting of unusual/unexpected events or incidents involving Yakima Neighborhood Health Services (YNHS) clients, visitors or staff which adversely affect or could adversely affect the quality of care provided.

Objectives:
Documents occurrences for prompt investigation and appropriate follow-up.
Permits early identification and timely reporting of potential legal claims.
Helps identify patterns and trends for performance improvement opportunities.
Complies with accreditation standards and regulatory requirements.

Definition:
A reportable event is any unusual or unexpected situation/outcome not consistent with routine operation of Yakima Neighborhood Health Services or the routine care of a client. The event may be one that has occurred or might occur, an accident or situation that might result in an accident, or any other unusual event the staff member wishes to report. Examples of such events include (but are not limited to):
Unexpected/adverse outcomes of medical treatment
Treatment-related client injuries
Deviations from procedure
Medication errors
Equipment/facility problems
Needle-stick injuries
Personal threat to staff
Physical injuries
Lost YNHS keys
Lost YNHS equipment

Procedure:
The staff member who witnesses, discovers, or is involved with a reportable event is responsible for reporting to a supervisor and for filling out the YNHS Incident Report (Appendix L, INCIDENT REPORT). The Incident Report should be completed by end of shift and given to a member of the management team. (If an incident involves violence or threat of violence notify an administrator immediately in addition to completing a report).
A member of the management team should document any investigation or action taken on the Action Plan portion of the Incident Report form. Promptly forward the Incident Report to the Administration office file.

The Safety Committee reviews applicable Incident Reports and tallies for trends.
Incident Reports are secured with the HR Manager.

Guidelines:
The Incident Report form should not be photocopied except for purposes of organizational review.
Copies of incident reports made for review should be shredded.
The reports should not be posted on bulletin boards or placed in patient records.
The fact that the form was completed should not be referenced in patient records.
Incident Reports should not be the subject of "public" discussion.
Incident Reports should be limited to quality improvement and risk management activities. ←
Incident Reports are the property of YNHS and should not be distributed.

Standard 7.2

CHICAGO CITY-WIDE COLLEGE

City Colleges of Chicago

Awards This

CERTIFICATE OF RECOGNITION IN ADULT/CONTINUING EDUCATION

To

JOSE MORALES

For Successful Completion of

"THE RIGHT TO KNOW ACT"

On

February 8, 1989

0.2 C.E.U.

John R. Wozniak

Instructor

Yakima Neighborhood Health Services Job Title: Health and Homeless Outreach Worker

Minimum Qualifications:
Associate degree in behavioral or health sciences or related field and two years closely related work experience. Qualifying work experience may be substituted year for year for education. Good attention to detail; good written and verbal communication skills. Bilingual Spanish/English desirable. Candidate has not been sanctioned or excluded from participation in federal or state healthcare programs by a federal or state law enforcement, regulatory, or licensing agency.

Supervised By: Outreach Coordinator

Position(s) Supervised: None

Typical Physical Demands and Working Conditions:
Requires prolonged walking and standing, frequent bending, stooping or stretching. May involve lifting or positioning of patients. Requires corrected vision and hearing to normal range. Requires full range of body motion including manual and finger dexterity and eye-hand coordination. Required to work under stressful conditions and with patients who are often in discomfort and/or pain. May be exposed to communicable diseases and bodily fluids. Requires ability to sustain concentration in noisy and fast-paced environment.

Examples of Duties (this list may not include all the duties assigned):

- Identification and outreach to homeless persons to determine who is in need of services.
- Assessment of need to determine client limitations and strengths
- Provide information about available services from YNHS and other agencies.
- Provide assistance with securing food, shelter, clothing and referrals to other supportive services.
- Provide assistance in accessing entitlements and completing forms and applications.
- Develop individual care plans in consensus with staff and client.
- Crisis intervention.
- Teach living skills
- Advocate on behalf of clients.
- Maintaining confidentiality of client interactions and medical records.
- Participate in staff in-service meetings.
- Participate in quality assurance activities and peer review as requested.
- Maintain organized, clean, efficient and confidential work area.
- Represent YNHS in local meetings as requested.
- Perform related work and other tasks as requested.

Working Relationships:
All YNHS employees are expected to develop and maintain professional and courteous working relationships with all other YNHS employees, patients, visitors, health profession students, vendors, and volunteers of the organization. In addition, YNHS employees are expected to provide courteous and efficient service to health and social service agencies working with YNHS patients.

Salary Range:
Salary Level B

Approved by CEO _____
5/11/2015
F:\Support\Employment\Job Descriptions\Outreach Worker- Health and Homeless.doc

Yakima Neighborhood Health Services Job Title: Outreach RN

Minimum Qualifications:
Currently licensed as a Registered Nurse in the State of Washington. Skills in applying and modifying the principles, methods and techniques of professional nursing to apply ongoing patient care. Knowledge of medical equipment and instruments to administer patient care. Experience in ambulatory care, patient assessment and triage, and working with homeless or other disadvantaged populations. Bilingual Spanish/English desirable. Candidate has not been sanctioned or excluded from participation in federal or state healthcare programs by a federal or state law enforcement, regulatory, or licensing agency.

Supervised By: Homeless Health Care Coordinator

Position(s) Supervised: None

Typical Physical Demands and Working Conditions:
Requires prolonged walking and standing, frequent bending, stooping or stretching. May involve lifting or positioning of patients. Requires corrected vision and hearing to normal range. Requires full range of body motion including manual and finger dexterity and eye-hand coordination. Required to work under stressful conditions and with patients who are often in discomfort and/or pain. May be exposed to communicable diseases and bodily fluids. Requires ability to sustain concentration in noisy and fast-paced environment.

Examples of Duties (this list may not include all the duties assigned):

- Provide holistic nursing assessments, preventive medicine counseling, risk factor reduction intervention, and education to homeless persons residing on the streets, in shelters, missions, or other temporary housing through direct contact.
- Coordination of patient care through the clinics, assessments, treatments and procedures.
- Observes, records, and reports patient's condition and reaction to drugs and treatment to physicians, nurse practitioners, physician assistants, and midwives. Dispense medication as directed.
- Assist in the development and implementation of YNHS policies, protocols, standing orders and quality assurance standards.
- Develop and maintain working relationships with healthcare and social service professionals in the community serving YNHS patients.
- Participate actively in staff in-service trainings and nurse meetings.
- Work in coordination with other YNHS staff to develop education programs for YNHS homeless patients and staff.
- Maintain organized, clean, efficient and confidential work area.
- Represent YNHS in local meetings as requested.
- Perform related work and other tasks as requested.

Working Relationships:
All YNHS employees are expected to develop and maintain professional and courteous working relationships with all other YNHS employees, patients, visitors, health profession students, vendors, and volunteers of the organization. In addition, YNHS employees are expected to provide courteous and efficient service to health and social service agencies working with YNHS patients.

Salary Range:

Approved by CEO _____
5/11/2015
F:\Support\Employment\Job Descriptions\Outreach RN.doc

Example contracts and outline of jobs

TOPIC: COMPLIANCE- CONTRACT MONITORING

PURPOSE: To ensure care treatment or services provided through contractual agreements are provided safely and effectively.

POLICY: PCC acknowledges the importance of monitoring relationships with contracted service providers through evaluation and management of the organizations expectations outlined in the agreement. Outlined below demonstrates the contract relationship, level of responsibility within PCC and procedures directly pertaining to specific contracts.

PROCEDURE: PCC senior leadership reviews all contracts on an annual basis and identified the following as the highest risk/highest volume contractual agreements. These include:

- Thresholds, Inc.
- Quest
- Global Insight Solutions
- Alliance

THRESHOLDS, INC.

LEVEL OF RESPONSIBILITY: Director of Behavioral Health

1. Director of Behavioral Health (BH) monitors monthly productivity of contracted service providers through the outlined agreement. PCC's Financial Analyst provides Director of BH monthly productivity reports for the department. The Director of BH will review the monthly report of achieved productivity with PCC's CEO and Thresholds, Inc.'s leadership (e.g. Chief Medical Officer).

2. Quarterly meetings occur between PCC Director of BH, Thresholds, Inc. leadership including CMO and clinical case managers. The purpose of these meetings will be to review the following:

- quarterly year to date productivity of expected service provision
- administrative bidirectional referrals between the representative agencies
- high risk case reviews and treatment planning
- health information exchange
- revenue/expense reports

QUEST

LEVEL OF RESPONSIBILITY: Chief Operating Officer

1. The Chief Operating Officer monitors the services provided by Quest at PCC sites. This includes the provision of discounted services as required to PCC patients under 200% of the Federal Poverty Level.

2. A monthly meeting is held with the Chief Operating Officer, clinic administrators, and several key members of the Quest management team. At these meetings, the following items are reviewed:

- Quality of services provided
- Onsite phlebotomy staff issues or concerns
- Billing issues or concerns
- Opportunities for additional testing

GLOBAL INSIGHT SOLUTIONS

LEVEL OF RESPONSIBILITY: Director of Billing

1. The Director of Billing monitors, audits and reconciles all services provided by Global Insight Solutions (known as GIS). Claim and billing services provided by GIS include: electronic claim submission and claim follow up; processing of all claim payments; patient payment arrangements; bad debt determination and adjustments; generation of patient statements every 30 days.

2. The PCC Director of Billing meets with key members of the GIS team on a monthly basis to go over the following areas:

a. Accounts Receivable (aging report; activity taking place on outstanding claims).
b. Collection staff productivity (tasks assigned and completed).
c. Results of audit that the PCC Director of Billing conducts on EOB's posted by GIS staff.
d. Any other outstanding issues that may need to be addressed (Centricity updates; workflow revisions; etc.)
e. Review any insurance updates and training needed for GIS/PCC Staff.

ALLIANCE

LEVEL OF RESPONSIBILITY: Director of Health Information and Technology and Medical Director of EHR

1. Director of Health Information and Technology is responsible for all administrative activities related to EHR. Medical Director of EHR is responsible for all clinical aspects of EHR. These two individuals work together as a team to interface with Alliance of Chicago Community Health Services LLC.

2. PCC's Director of Health Information and Technology along with Medical Direct of EHR meet on a monthly basis with the Alliance to review services provided by the Alliance as outlined in contract which include reviewing the following:

- Evaluate performance issues and ensure continuous functioning of the Licensed Software on the basis of a 99.7% network up time
- Meet meaningful use requirements
- Provide monthly service pack updates
- Train staff to operate and utilized the Licensed Software
- Generate customized reports
- Advise and consult with PCC in respect to customizing clinical content for the Licensed Software

REQUEST FOR APPROVAL OF NEW HIRE

Name of Candidate _____ Proposed Hire Date _____

Position _____ Potential Supervisor _____

Suggested Salary _____ Salary Offered _____

Please check the items below that have been completed

- ☐ Candidate has provided a resume
- ☐ Candidate has a valid driver's license or state ID
- ☐ Candidate has a valid social security number
- ☐ Candidate has negatively tested for drugs
- ☐ Candidate has completed Interfaith House application for employment
- ☐ Candidate has been interviewed by phone and in person
- ☐ Background check has been started
- ☐ References and credentials have been checked and documented
- ☐ Candidate meets all requirements of position

If no, please list action plan to meet requirements (schooling, training course, receive certification, etc.) and the date by which actions will be completed

_____

_____

CANDIDATE APPROVED? YES_____ NO_____

If no, please list reason(s): _____

Human Resources Director Signature _____ Date _____

Executive Director Signature _____ Date _____

TOPIC: COMPLIANCE- EXCLUSION LISTS SCREENING

PURPOSE: To ensure that PCC Community Wellness Center does not affiliate with Ineligible Persons.

LEVEL OF RESPONSIBILITY:

All current and potential staff
All current and potential Board members
All current and potential contractors
All current and potential vendors
All current and potential volunteers
Individuals or Organizations that affiliate with PCC Community Wellness Center

POLICY: PCC Community Wellness Center must comply with all federal and state requirements for screening of all existing and current individuals that affiliate with PCC Community Wellness Center. This includes staff, Board members, contractors, vendors and volunteers.

Definitions
Ineligible Person- An individual or organization who is debarred, suspended, proposed for debarment, excluded or disqualified or otherwise declared ineligible to participate in a Federal or State health care program, or may become debarred, suspended, proposed for debarment, excluded or disqualified or otherwise declared ineligible to participate in a Federal or State health care program on the basis of a criminal conviction, loss of licensure or otherwise.

Exclusion lists- Include:
Federal- www.oig.hs.gove/exclusions/index.asp
Federal -www.sam.gov
State- www.state.il.us/agency/oig/search.asp

PROCEDURES:

1. PCC Community Wellness center shall complete screening of all individuals and organizations prior to the commencement of their affiliation with PCC. PCC also shall complete screening of all individuals and organizations affiliated with PCC on a quarterly basis. As appropriate, PCC may conduct random screenings in addition to regularly scheduled screenings.

2. Screening of individuals and organizations shall be conducted by PCC's Human Resources department and the CEO's Administrative Assistants under the supervision of PCC's Director of Performance Improvement and Compliance.

3. The HR department and Administrative Assistants will notify the Director of Performance Improvement and Compliance, if any individual or organization currently or potentially affiliated with PCC is determined to be an Ineligible Person. The Director of Performance Improvement and Compliance and the President and CEO shall determine on a case-by-case basis whether PCC may begin or continue the potential affiliation.

4. The Director of Performance Improvement and Compliance shall maintain the records of all screenings for a period of six years after the termination of PCC's affiliation with the individual or organization in either a paper or electronic format.

Original: 8/12
Reviewed: 8/14

Development Department
Volunteer Confidentiality Agreement

I agree to respect and protect the clients, donors, volunteers and staff of Interfaith House. Specifically I agree to maintain forever the confidentiality of all information given to me about or by clients, donors, volunteers, and staff and to maintain forever the anonymity of all clients and donors.

I understand that I must withhold information about clients and about client identity from all of those not affiliated with Interfaith House. I understand that this includes refusing to acknowledge that anyone is or is not a client of Interfaith House.

During my orientation at Interfaith House on_____, this policy regarding confidentiality was explained to me. By signing this document I agree to follow the confidentiality policy of Interfaith House and understand that a violation of this policy will lead to corrective action and/or termination as a volunteer for Interfaith House.

_____
Print Name

_____
Sign Name

interfaithHOUSE

Restoring health, rebuilding lives, returning home.

Volunteer Information

Date: __ / __ / ____

Name: _____

Address: _____

_____

City, St, Zip _____

Phone: _(___)_____

Email: _____

If you are volunteering with a group, what is the name of that group?

_____

How did you hear about Interfaith House?

_____

Thank you for all that you do!

Volunteer info

Volunteering at Interfaith House

Placement, Training and Supervision

All individual volunteers will have an assigned supervisor. At the first meeting with the supervisor, the volunteer will review goals and objectives for the placement and establish a schedule. Supervisors and volunteers will work together to complete appropriate training and to further discuss volunteer responsibilities. The supervisor will become the volunteer's main contact regarding their volunteer position.

Absences

At Interfaith House we depend on volunteers for our daily operations. If you plan to miss your scheduled shift, please contact your supervisor and central desk (ext. 234) at least two hours before the start of your shift. *Thank you for your courtesy.*

Sign-in/ Sign out

Please remember to sign in and out. The volunteer log is located in the reception area on the administrative side of the building. Keeping accurate records of volunteer service gives Interfaith House the opportunity to recognize volunteers for their service, write recommendations for volunteers, and serves as an example to funders of the support Interfaith House receives from the community. *Thanks for your cooperation.*

Benefits of Volunteering at Interfaith House

- **A chance to make a lasting difference in an urban community.**
- Hands-on experience with a non-profit organization.
- Working alongside staff committed to ending the cycle of homelessness.
- Being involved with creative projects (i.e. gardening, painting, etc.)
- Free meals while volunteering (if present during dining hours); recommendation letters and/or community service hours
- Learning more about current issues related to homelessness.

VIII. Employee Evaluation Procedures

New employee evaluations are required by the end of the probationary period (in most cases, this is six months). An initial progress evaluation may be held at the end of the first three months to discuss progress in the new position.

All staff should be evaluated on an annual basis.

- Evaluations of non-supervisory staff should be prepared and reviewed by the management team, summarized and presented to employees. All evaluations should be kept as part of individual personnel files.
- Evaluations of management staff should be prepared and reviewed by the CEO and his/her designee.
- Evaluations of medical / dental providers should be prepared and reviewed by the Medical or Dental Director, CEO and COO, and presented to the medical / dental provider.

The Human Resources Manager is responsible for monitoring the schedule of evaluation dates for managers and the employees in his/her department.

Example

Policy regarding Evaluations

Performance Evaluation Program

Performance evaluations are considered an on-going process. Evaluations will be conducted after the six month introductory period, although they may be conducted earlier, particularly if there is an indication of poor work performance. Thereafter, annual performance evaluations will be conducted.

The performance evaluation program is a process by which job expectations and goals are mutually set annually by employees and their supervisors. This is a scheduled opportunity for employees and their supervisors to offer their individual assessments of the previous year's activities and to plan for the upcoming year.

An evaluation form will be provided to both the employee and the supervisor. The supervisor and employee will then meet to discuss their individual assessments and to complete and sign an Action Plan for the coming year.

_____ _____

Executive Director: Date:

YAKIMA NEIGHBORHOOD HEALTH SERVICES
Department-Specific Safety Instruction

Purpose:
To provide newly hired employees training on department specific safety issues.

Procedure:
Each department will include in training orientation for newly hired individuals a list of safety instruction that is individualized for that department. Items in each department should include:
Medical/Dental Reception:
Code Blue Responsibilities
Ergonomics
Evacuation plan
Fire extinguisher locations
Hazardous chemical training
Panic/False Alarm information
Patient safety (maintaining an exit, Code 99)
Pull station locations
Threatening call report
Violence in the Workplace Prevention training

Medical
Code Blue Responsibilities
Ergonomics
Evacuation plan
Fire extinguisher locations
Hazardous chemical training
Infection control
Panic Lever locations
Patient safety (maintaining an exit, Code 99)
Pull station locations

Dental
Code Blue Responsibilities
Ergonomics
Evacuation plan
Fire extinguisher locations
Hazardous chemical training
Infection control
Panic Lever locations
Patient safety (maintaining an exit, Code 99)
Pull station locations

Accounting/Billing/HCI
Code Blue Responsibilities
Ergonomics
Evacuation plan (to include basement exit as appropriate)
Fire extinguisher locations

Hazardous chemical training
Panic Lever locations
Panic/False Alarm information
Patient safety (maintaining an exit, Code 99)
Pull station locations
Threatening call report
Violence in the Workplace Prevention training

MSS/WIC
Code Blue Responsibilities
Ergonomics
Evacuation plan
Fire extinguisher locations
Hazardous chemical training
Home visitor safety
Infection control plan
Panic Lever locations
Patient safety (maintaining an exit, Code 99)
Pull station locations
Violence in the Workplace Prevention training (reception)

Housekeeping/Facility Assistant
Bloodborne pathogen training
Code Blue Responsibilities
Equipment specific training
Hazardous chemical training
Location of Spill Kits
Ergonomics
Violence in the Workplace Prevention training

Pharmacy
Code Blue Responsibilities
Ergonomics
Evacuation plan
Fire extinguisher locations
Hazardous chemical training
Panic Lever locations
Patient safety
Violence in the Workplace Prevention training
Pull station locations
Threatening call report

Outreach
Home visitor safety
Ergonomics
Evacuation plan
Fire extinguisher locations
Hazardous chemical training

Hazardous chemical training
Panic Lever locations
Panic/False Alarm information
Patient safety (maintaining an exit, Code 99)
Pull station locations
Threatening call report
Violence in the Workplace Prevention training

MSS/WIC
Code Blue Responsibilities
Ergonomics
Evacuation plan
Fire extinguisher locations
Hazardous chemical training
Home visitor safety
Infection control plan
Panic Lever locations
Patient safety (maintaining an exit, Code 99)
Pull station locations
Violence in the Workplace Prevention training (reception)

Housekeeping/Facility Assistant
Bloodborne pathogen training
Code Blue Responsibilities
Equipment specific training
Hazardous chemical training
Location of Spill Kits
Ergonomics
Violence in the Workplace Prevention training

Pharmacy
Code Blue Responsibilities
Ergonomics
Evacuation plan
Fire extinguisher locations
Hazardous chemical training
Panic Lever locations
Patient safety
Violence in the Workplace Prevention training
Pull station locations
Threatening call report

Outreach
Home visitor safety
Ergonomics
Evacuation plan
Fire extinguisher locations
Hazardous chemical training

Appendix W
YAKIMA NEIGHBORHOOD HEALTH SERVICES
PROCEDURE AND SAFETY REVIEW OUTLINE

1) Organizational structure and values
   a) Organizational chart
   b) Chief Executive Officer
   c) Organizational Values
2) Personnel Handbook
   a) Employee Health Services
   b) Swipe Cards
   c) Family Leave
3) Patient Fees and Charges
   a) Patient Registration
   b) Funding of YNHS services
4) Managed Care
   a) Managed Care entities
   b) Participating Managed Care Plans
   c) YNHS Responsibilities for Managed Care Patients
   d) Healthy Options Rules
   e) Basic Health Plan
   f) Health Coverage – Special Projects
5) Confidentiality
   a) Employees
   b) Patients/Clients
      i) Notice of Privacy Practices
      ii) Authorization to release protected health information
      iii) Internet
   c) Security
      i) Network and program accountability
      ii) Phone system
      iii) Long distance codes
      iv) Building security
      v) Computer security and password information
6) Joint Commission Accreditation
   a) YNHS Mission
   b) Accreditation process
   c) Adverse Drug Reaction
   d) Staff participation in QI program
   e) Patient Rights & Responsibilities
   f) Education of Patients
   g) Skills Checklists
   h) Competencies
      i) Age-specific
      ii) Cultural
   i) Safety
      i) General Safety Rules
      ii) Unattended children

Excerpted from Safety and Emergency Management Manual

iii) Safety Committee
iv) Incident Reporting
v) Ergonomics
vi) Electrical

j) Emergency Management
i) Power Failure
ii) Natural Gas Leak
iii) Earthquake
iv) Systems Failure

k) Hazardous Chemicals
i) Safety Data Sheets (SDS)
ii) Hazardous Spills

7) Emergency Codes
a) Code Red
i) Announcing
ii) Fire Safety
iii) Evacuation

b) Code Blue
i) Announcing
ii) Code Blue Team

c) Code Pink
i) Announcing
ii) Staff response

d) Code Pink to All Exits
i) Announcing
ii) Staff response

e) Code Silver
i) Announcing
ii) Staff response

f) Panic Levers

8) Virtual Tour
a) Eye wash stations and kits
b) "Area Clear and Secure" signs
c) Stair Chair
d) Spill kits
e) Safety bulletin board
f) Evacuation Boxes
g) Body fluid exposure packets
h) Urgent care cart
i) Security codes, alarm procedures, evacuation bags, elevator keys
j) Emergency exits in Business Center
k) Gas shut off valves
l) Panic levers

9) Security
a) Incident reporting
b) Nametags
i) Employees
ii) Visitors

c) weapons procedure
d) violence in the workplace
    i) warning signs of escalating behavior
    ii) de-escalation techniques
e) Restricted access to medications
f) Department specific training
g) Lighting and buddy system
h) Computer/communications security

10) Miscellaneous
a) Mortality Review
b) Threatening Phone Call Report
c) Ethical Concern Form

11)Infection Control
a) Staff immunizations
b) Work restrictions for health care personnel
c) Latex allergy
d) Universal precautions
e) Bloodborne pathogens
    i) HIV
    ii) HBV
    iii) HCV
    iv) Preventive measures
f) Personal Protective Equipment
g) Work practice controls
h) Engineering controls
i) Regulated waste disposal
j) Tuberculosis Prevention and control

12)Bloodborne Pathogen Training (as required by position)
a) Definition
b) Potentially Infectious Materials
c) Occupational Exposure
d) Bloodborne Diseases
    i) HIV
    ii) Hep B
    iii) Hep C
e) Exposure Control Plan
f) Universal Precautions
g) Work Practice Controls
h) Engineering Controls
i) PPE
j) Housekeeping
k) Hazards Communications
l) Hep B Vaccinations
m) Post Exposure Follow up
n) Training & Record Keeping

TOPIC: IT- ENCRYPTION

PURPOSE: To define standards for encryption installed on PCC mobile devices.

POLICY: Encryption software is the most effective way to achieve data security. PCC installs Symantec PGP Whole Disk Encryption for Windows on laptop devices.

LEVEL OF RESPONSIBILITIES:
All Staff
PCC IT Staff

PROCEDURE:

Definition

The translation of data into a secret code. Encryption is the most effective way to achieve data security. To read an encrypted file, you must have access to a secret key or password that enables you to decrypt it. Unencrypted data is called plain text; encrypted data is referred to as cipher text.

Encryption Key

An encryption key specifies the particular transformation of plain text into cipher text, or vice versa during decryption.

Sensitive data and files shall be encrypted before being transmitted through networks. When encrypted data are transferred between agencies, the agencies shall devise a mutually agreeable procedure for secure key management. In the case of conflict, PCC shall establish the criteria in conjunction with the IT Director, Privacy Officer or appropriate personnel. PCC employs several methods of secure data transmission.

Installation of authentication and encryption certificates on the e-mail system

Any user desiring to transfer secure e-mail with a specific identified external user may type the word ENCRYPT in the subject line of the email and the recipient will receive a notice through the Barracuda device.

Use of WinZip encrypted and zipped e-mail

This software allows PCC personnel to exchange e-mail with remote users who have the appropriate encryption software on their system. The two users exchange private keys that will be used to both encrypt and decrypt each transmission. Any PCC staff member who desires to utilize this technology may request this software from the IT Director or appropriate personnel.

Example trainging

New Hires and Cultural Competency Training.

In order to meet the needs of our residents, Interfaith House ensures that staff members and other providing services are well-informed about the scope of their job responsibilities and agency policies and receive adequate training to execute all job responsibilities with confidence and skill. Interfaith House hires staff who have the qualifications needed to meet the needs of residents and reflect the diversity of the populations we serve, to assure this, staff will participate in cultural competency training yearly.

Procedure

1. Interfaith House publicizes all job openings using channels that are likely to attract employees who reflect the cultural and linguistic diversity of the populations we serve.

2. Interfaith House provides orientation for all newly hired staff within the first week after their start date, and provides initial training within the first month.

3. Interfaith House screens new staff to ensure that they have:

   a) Appropriate skills, experience and licensing certifications to perform assigned responsibilities
   b) Positive references from past employment experiences, if possible

4. Interfaith House provides all staff with a personnel manual and a training manual or orientation manual that contains the following:
   a) Interfaith House mission statement
   b) Interfaith House code of ethics
   c) Information about Interfaith House's programs and services
   d) Personnel and program policies and procedures
   e) Samples of properly-completed paperwork, including reports to funders
   f) Organizational charts
   g) Explanation of performance review processes
   h) Orientation to standards of care for homeless individuals
   i) Orientation to standards of care for people living with HIV/AIDS

5. Interfaith House encourages all new staff to attend trainings that will benefit them in their roles.

_____ _____

Executive Director Date

7/8

Excerpted from the YNHS Personnel Handbook

Harassment Prohibited

The Organization believes that all employees should work in an environment that is free of unlawful harassment and discrimination. All employees have the duty to prevent unlawful harassment at the workplace. Additionally, all employees are expected to conduct themselves in a way that fosters a comfortable, professional and respectful working atmosphere for other employees.

Harassment in general

Harassment based on race, sex, religious or spiritual beliefs, national origin, sexual orientation, age, disability, marital or veteran status, or any other protected status is a violation of organization policy and is strictly prohibited. While the following types of specific behavior may not necessarily constitute harassment, they are prohibited at the Organization: slurs, graffiti, negative stereotyping, racial, ethnic or religious or spiritual epithets, and written or graphic material that show hostility to an individual or group. This is not an exclusive list of behaviors that may violate this policy.**Sexual Harassment And Other Inappropriate Conduct**

One type of prohibited harassment is sexual harassment. It can consist of unwelcome sexual advances, requests for sexual favors and other verbal or physical conduct of a sexual nature or that is otherwise based on gender when:

a. submission to the conduct is made either explicitly implicitly a term or condition of an individual's employment;
b. submission to or rejection of such conduct by an individual is used as a component of the basis for employment decisions affecting that individual; or
c. the conduct has the purpose or effect of substantially interfering with an individual's work performance or creating an intimidating, hostile or offensive working environment.

Any conduct that meets the above definition is prohibited at the Organization. This expressly includes explicitly or implicitly conditioning any term of employment (such as continued employment, wages, evaluation, advancement, time off, assigned duties or shifts) on the provision of sexual favors.
Sexual harassment may be difficult to recognize in certain circumstances. Although the following types of specific behavior may not necessarily constitute harassment, employees should not engage in them at the Organization: touching or grabbing a sexual part of any individual's body; touching or grabbing any part of an individual's body after that person has indicated or it is known that contact is unwelcome; continuing to ask a person on a date when that person has indicated that he or she is not interested; displaying or transmitting pornography; and using sexually vulgar or explicit language. This is not an exclusive list of behaviors that may violate this policy.

Procedures Relating To Violation Of This Policy

If you believe that you or another person may have been subjected to harassment or discrimination or if you believe that the conduct of any person at the workplace violates this policy, you are obligated to promptly report such conduct or statements to the President / Chief Executive Officer or her designee.

Your report will be investigated promptly. The Organization will protect the confidentiality of those involved to the extent that it is consistent with our need to examine good faith concerns or cooperate in an investigation under this policy. No person will be retaliated against by the Organization for good faith voicing of concerns or cooperating in an investigation under this policy. It is a serious violation of this policy for any employee to retaliate against any person because he or she reports a violation of this policy or has participated in an investigation.

All organization employees are required to comply with this policy. Violations of this policy will result in discipline up to and including termination with the Organization.

ON BACK Example self-audit policy

Program Team – Chart Review Policy

Charts will be reviewed on a monthly basis for the intakes 2 months prior to the date of review. For example, in the month of March, all the intakes from January will be reviewed. This will ensure that all funder-required forms have been signed, dated, and included in the chart. This process will also ensure that all assessments and necessary referrals have been made and that proper supporting documentation is in the chart.

Procedure

1. The Program Director will designate which program manager meeting will be used for chart review
2. The Program Director, or designee, will ensure that the appropriate charts have been pulled for review prior to the meeting.
3. The Program Director will ensure that a census and chart review guide (a blank chart review form) are provided for each manager.
4. Each resident's chart on the census will be reviewed and a chart review form completed and signed to document the results. Any follow-up required by staff will be completed following the chart review and any supervision action needed will be done so by the appropriate manager.

_____ _____

Executive Director

Neighborhood HEALTH

Yakima Neighborhood Health Services
12 South 8th St, PO Box 2605
Yakima WA 98907-2605
Phone (509) 454-4143 Fax (509) 454-3651
www.ynhs.org

RESPITE EXIT

Standard 7.2

CLIENT EXIT INFORMATION AND SURVEY

Client's ______ DOB: 8/10/67.

Address ______ Unit # 5

Date Moved in 5/8/14 Income $ 197 Source ABD

Date Moved out 7/10/14 Income $ 197 Source ABD

We hope that your stay at Respite helped you recover and get back on track.

- Your new address: 1107 S. Naches #9 Yak. WA 98901 Phone # 930 3083 594 4032.
- Where are you moving to:

TTS Connections

Moving with friends/family	Shelter	Leaving Town	Don't know
X Transitional Housing	Voucher / subsidized rental	Treatment Center	Other
Section 8 Public Housing	Section 8 Voucher	Jail	

- Reason for Leaving: Completed program.
- Comments/suggestions: program helped me in all my medical appt! I.D replacement / Bus passes for appointments when needed. also a place for my mail, miss. #. I don't know the main goal was permanent housing which they also helped me get all needed paperwork for the clean sober living. This is such a much needed program. I am so much more relieved :) happy, unstressed. Thank you.

Client Signature ______ Date 7/10/14

☐ Client moved without notice

Staff Signature [signature] Date 7/10/14

Accredited by the Joint Commission

RESPITE Exit Survey #008