
COVID19 RESPITE FACILITY FOR PEOPLE EXPERIENCING HOMELESSNESS



APRIL 1, 2020
CITY OF NEW HAVEN

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1 | Introduction

Protocol Disclaimer:

We are pleased to share this protocol/strategic plan with others who might find it useful. This document represents a set of recommendations from the authors. Due to time, financial and logistical constraints the COVID respite program in New Haven will likely look slightly different than the program described here. For example, we repeatedly reference a COVID + unit and unit for individuals under investigation (PUI - with testing pending). We are piloting this program with only a COVID + unit and hope to expand to include a PUI unit in the future. We note that this protocol is in “draft form” as it will likely change tremendously as we implement and iterate the program. We hope you will find these recommendations helpful.

We opened our doors to our first patients on April 10th, 2020. Since its opening a number of operational challenges have emerged and we are in the process of developing an even more detailed staff guide.

Program Strategic Objective:

To provide a safe place for people experiencing homelessness, who are not sick enough for hospitalization, to recuperate and quarantine while recovering from COVID19.

Program Aims:

To provide a safe place for individuals, in the shelter or transitional living environments, to rest, sleep, be provided food and other essential resources while they recuperate until no longer infectious from COVID19

- To provide access to medical supervision for clients
- To protect the public health and reduce the spread of the virus within congregate facilities

Program Overview:

The COVID19 respite facility is a voluntary living environment, located at Hill Regional Career High School (140 Legion Avenue, New Haven, CT 06519) for individuals who are experiencing homelessness, are confirmed COVID19+, and do not require hospitalization. The facility consists of separated decontaminated areas and infectious areas occupied by patients and associated medical processes. The facility is staffed by two medical staff and one administrative staff on site with a security detail provided by New Haven Police Department and custodial staff provided by Eco-Urban Pioneers. Medical staff will remain with patients to tend to any issues that may arise and ensure the daily functioning of the facility. Administrative staff and security detail will remain in decontaminated areas and will not interact with patients unless required in an emergency. The facility is also staffed by one medical director, one site manager, and one behavioral health specialist who will remain off site unless required to be present for emergency situations.

PPE will be provided by the New Haven Emergency Operations Center for daily staff and will be available for remote staff for emergency situations. Both staff and patients will receive three meals per day provided by local restaurants on a rotating basis as contracted by the city. Laundry services, entertainment devices, and basic household/hygiene items will also be provided by the City of New Haven to ensure a high standard of care for patients. These policies and practices are detailed below.

Program Priorities:

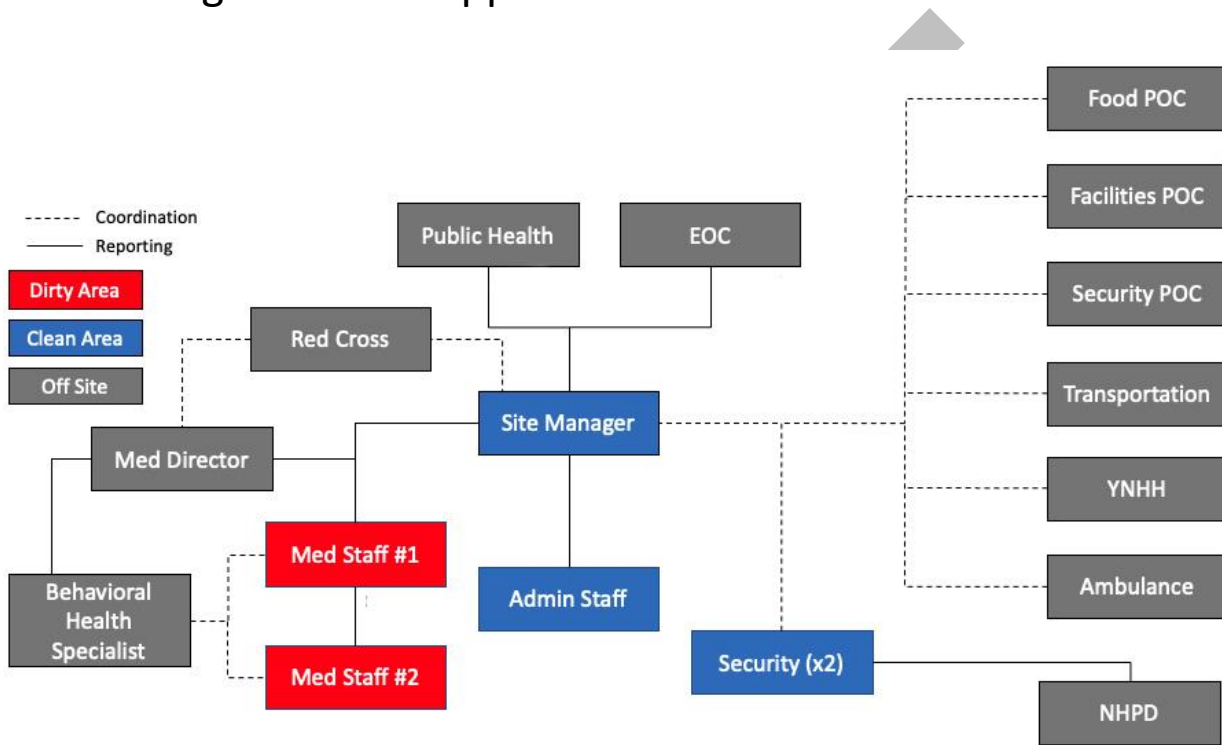
The COVID19 respite program provides care based on the principles of autonomy and respect for people. Individuals experiencing homelessness are at high risk for COVID-19 infection and complications due to underlying health conditions and systemic barriers to receiving appropriate medical care. The priority of this program is to remove barriers to self-isolation and care for this population while preserving individuals' right to choose.

Guiding Principles:

- Our facilities promote “Come as you are” policies, meaning there should not be stringent conditions for use of the space or eligibility criteria that would create categories of excluded people, including people who use non-prescribed drugs. ([from document by Sex Workers and Allies Network and Global Health Justice Partnership](#))
- Our facilities promote **“Harm Reduction” principles** including but not limited to:
 - Non-judgmental, non-coercive provision of services and resources to people who use drugs in order to assist them in reducing attendant harm
 - Does not attempt to minimize or ignore the real and tragic harm and danger associated with licit and illicit drug use.
- Our facilities approach care from a [Trauma informed perspective](#) and avoid retraumatization whenever possible
- Our facilities **respect the clients that we serve, provide methods for guests to offer feedback** and ensure that those most impacted are at the table in deciding what is best for them (note while this is an intention it was not the case in the development of these protocols).
- **Abolition / Decarceration:** Police /security involvement must not be implemented in such a way that will further surveil, criminalize, or harm this population. This includes, but is not limited to, forced containment, criminalization of possession of drugs or paraphernalia or of sex work. ([from document by Sex Workers and Allies Network and Global Health Justice Partnership](#))

2 | Staffing Plan

Shelter Organization Support Structure



Staffing References

Columbus House (New Haven medical respite)	Overnight: 2 staff/75 clients Daytime: 3 staff/75 clients
SCRC (local New Haven shelter)	Overnight: 24 inpatient capacity: 10 rooms, 2 patients/room, 2 rooms with 4 patients/room Overnight: 2 LPNs, 2 RNs, 1-2 CNAs, 1 Security Guard
Considerations:	<p>COVID19 Respite staffing model combines features of shelters and inpatient medical facilities. It is not a medical inpatient facility</p> <p>Open floor plan allows for easier monitoring with less staff (although challenges for privacy)</p> <p>Goal is to balance client autonomy and privacy with necessary medical oversight, while limiting number of staff needed, limiting staff exposures & use of PPE</p> <p>Goal to use virtual/remote tools as much as possible.</p>

Role & Prerequisites	Responsibilities	Shift	PPE needed
Location: Onsite (contaminated and decontaminated zones)			
Med Staff #1 (CNA/LPN/MA) Licensure as per degree Training in PPE	Intake Vitals Facilitate schedule	8 hr	2 sets/shift: <ul style="list-style-type: none"> • N95 • Goggles/Face Shield • Gown • Shoe covers • Surgical cap • Gloves • Oxivir wipes
Med Staff #2 (RN) Licensure as per degree Training in PPE	Assess/Monitor health status Med dispensing Help facilitate schedule Maintain health record Interface with MD/APRN on call Interface with Operational Director PPE Steward Initiate clinical escalation PRN	8 hr	2 sets/shift: <ul style="list-style-type: none"> • N95 • Goggles/Face Shield • Gown • Shoe covers • Surgical cap • Gloves • Oxivir wipes
Custodial Staff	Complete custodial duties as outlined in contract between City of New Haven and Eco-Urban Pioneers	8 hr	2 sets/shift: <ul style="list-style-type: none"> • N95 • Goggles/Face Shield • Gown • Shoe covers • Surgical cap • Gloves • Oxivir wipes
Location: Onsite (decontaminated zone)			
Security Detail from NHPD As per city Training in PPE	Assist with security	8 hr shift	<ul style="list-style-type: none"> • N95 • Gloves

Administrative Staff/Social Worker Licensure as per degree Training in PPE	Assist with administrative and logistical functions of the facility Coordinate with Operational Director when necessary Administer intake questionnaires and refer to behavioral health specialist as appropriate Arrange disposition for patients	8 hr shift	<ul style="list-style-type: none"> • N95 • Gloves
Operational Supervisor As per city Training in PPE	Supervise shift change Supervise daily functioning of the facility	24 hr remote call/present for shift changes	<ul style="list-style-type: none"> • N95 • Gloves
Location: Remote			
Operational Director (nonmedical, remote) As per city	Interface with Med Staff Interface with outside vendors – laundry, food, pharmacy, and custodial service Interface with City	24hr remote call	None
Med Director on call (MD/APRN) Licensure as per degree Training in PPE	Clinical guidance to Med Staff 2 (RN) Provide telehealth services to clients Write prescriptions If need be, in person visit Respond to clinical escalation	24hr remote call q2-3d call	1 set of full PPE if in person visit
Psychiatrist On Call Licensure as per degree	Consultation re- medication management Advise re-behavioral health emergencies	8A-10P remote call	None

PPE Requirements

Point of Contact - _____

The City of New Haven will provide four weeks supply of PPE (as outlined below) prior to operating the facility.

Daily PPE Need:

	Med Staff 1	Med Staff 2	Admin Staff	Operations Supervisor	NHPD	Med Director	Behavioral Specialist	Custodial Staff	Patients Requiring Transportation	Total
N95	6	6	6	3	6	1	1	6	2	37
Goggles or Face Shield	3	3	3	1	3	1	1	3	0	18
Gloves (S)	-	-	-	-	-	-	-	-	-	1 box
Gloves (M)	-	-	-	-	-	-	-	-	-	1 box
Gloves (L)	-	-	-	-	-	-	-	-	-	1 box
Disposable Gowns	12	12	0	0	12	1	1	12	2	52
Shoe Covers	6	6	0	0	0	1	1	6	2	22
Surgical Caps	6	6	0	0	0	1	1	6	2	22
Oxivir Wipes	-	-	-	-	-	-	-	-	-	2 cans

Total PPE Need (4 week supply):

ITEM	QUANTITY	SOURCE	CONFIRMED (Y/N)
N95	1036		
Goggles or Face Shield	18		
Gloves (S)	28 boxes		
Gloves (M)	28 boxes		
Gloves (L)	28 boxes		
Disposable Gowns	1456		
Shoe Covers	616		
Surgical Caps	616		
Oxivir Wipes	56 cans		

3 | Staff Onboarding

COVID-19

WHY HOMELESS POPULATIONS
ARE A HIGH-RISK GROUP



POOR HEALTH

High rates of chronic medical conditions, behavioral health conditions, infectious illnesses, acute illnesses, & exposure to elements.

CONGREGATE SETTINGS

Shelters, public transportation, soup kitchens, health clinics & other service venues where this population receives care are large, crowded congregate settings.



AN AGING POPULATION

Many people experiencing homelessness are older, have limited mobility, & have even higher rates of poor health.

LIMITED ABILITY TO FOLLOW PUBLIC HEALTH ADVICE

Washing hands, staying at home, & maintaining physical distance from others is often not possible for people without homes.



STIGMA & DISCRIMINATION

Communities regularly seek to block or remove people who are homeless. Laws often prevent housing & other services from being able to expand to meet the need.

For More Info:

www.nhchc.org

#VisualizeHomelessness

Source: www.nhchc.org/covidbrief

See our coronavirus resource page for more information and guidance on COVID-19: www.nhchc.org/coronavirus

NATIONAL
HEALTH CARE
for the
HOMELESS
COUNCIL

Building Relationships

KEY: Connection,
Trust, Respect

Due to past experiences, many unhoused people may distrust medical providers and other people in power

Relationships built on trust, understanding and respect are critical to providing good health care and keeping people engaged

TIPS FOR Relationship Building:

1. **Humility:** Be respectful, straight forward, interested and acknowledge your limitations
2. **Approachability:** Be curious, be kind, connect on a human level (ex: ask, "Where are you from?" "What kinds of work have you done?")
3. **Listen, don't judge:** provide clients the opportunity to be heard
4. **Boundaries:** know what yours are and maintain them; respect client's boundaries
5. **Self-Awareness:** this is hard work! Ask for help and make sure you're taking care of yourself. We all have judgements and prejudice; be aware of how it might impact clients.

Trauma Informed Care

Homelessness and sudden illness are in and of themselves traumatic; many people who you will be working with have chronic trauma which will be compounded during stressful times

TIPS FOR Providing Trauma Informed Care

1. **Body Language:** sit down, be on their level, acknowledge power dynamics
2. **Ask Permission** before you touch someone or perform a procedure
3. **Inform** clients about their care plan; **Provide options** when they are available
4. **Coping mechanisms** that may be perceived as harmful (smoking, using non-prescribed drugs, eating sweets, getting angry) are usually survival strategies that have helped people get through difficult situations; **pick your battles** and **support guests where they're at right now**

Grounding and De-Escalation

There are lots of ways to support clients who are having a hard time physically and emotionally

Start by slowing down, using a calm tone of voice giving clients physical space

TIPS FOR De-Escalation and Grounding:

1. **State what you observe:** ex: "Your voice is loud and you look scared and angry"
2. **Ask people what they need,** and do your best to provide it (within reason)
3. **Guided Imagery:** describe a relaxing view, a safe place
4. **Distraction:** change the focus, tell a story, offer TV or a magazine
5. **Grounding:** help clients to notice their breath, feel their feet on the ground
6. **Sensory awareness:** simple tactics like smelling an orange peel or running hands under cold water can help people stay present and calm

4 | Logistics

Security Plan

Point of Contact: _____

NHPD will provide two police officers with two patrol cars for any emergencies that may occur at the facility. The security personnel will be located outside the patient entrance and the loading dock entrance. Security will maintain radio communications with staff inside the facility. New Haven Police Department security detail and New Haven school system staff will monitor the facility remotely through Milestone.

Custodial Plan

Point of Contact: _____

The city has secured the use of existing contractors to conduct daily, thorough cleaning of the facility, including bathrooms and sleeping area following CDC guidelines/infection control guidelines. Eco-Urban Pioneers will be the contract custodial service.

Food Plan

Point of Contact: _____

City will contract with local food service providers (restaurants/grocers) to provide 3 meals each day for up to 50 people. Will include meal delivery to decontaminated area as agreed upon with contractor. Administrator at facility will receive meals and transfer to patient dining quarters via the patient entrance. Administrator will drop the food at the entrance and a medical staff from the contaminated side of the facility will pickup.

Laundry Plan

Point of Contact: _____

The City has procured two washing machines and two dryers. BOE staff are installing plumbing, vent and electrical connections. Equipment is operational as of April 1, 2020.

Transportation Plan

Point of Contact: _____

Transportation for patients who are discharged from the facility will provided by _____. Medical staff will ensure that the patient is wearing a surgical mask and gloves prior to entering the _____ vehicle. _____'s process for transporting COVID-19+ patients is as follows:

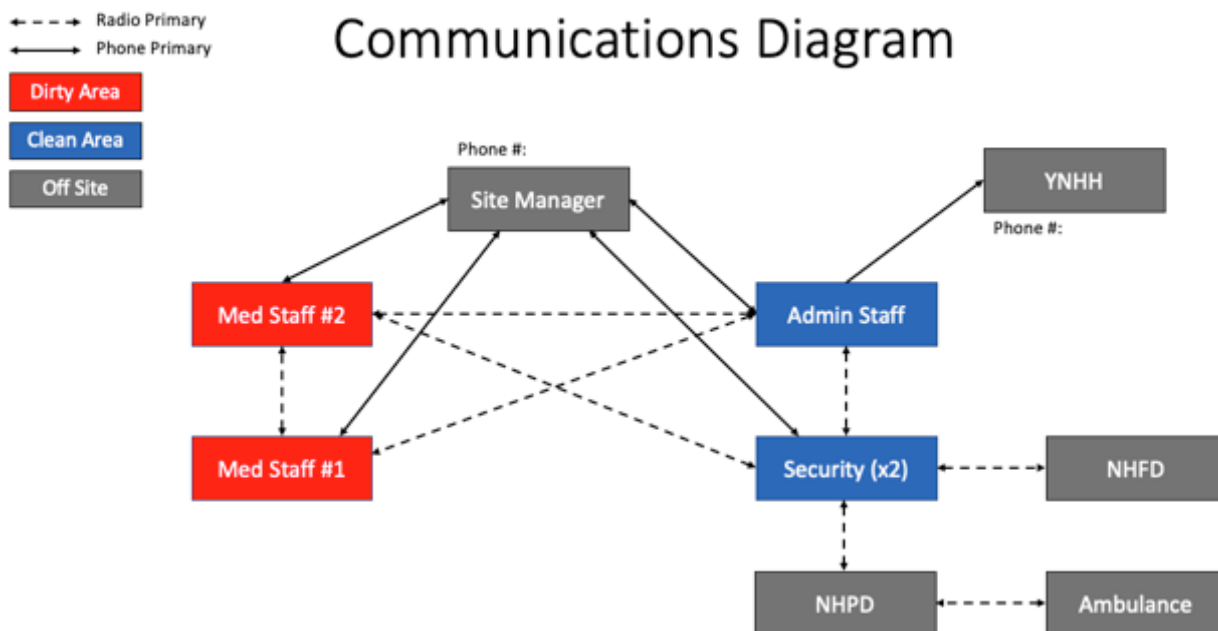
- All service requests MUST be made on the _____ phone line.
- All trips are charged to either a business account or pre-paid; no money or credit card exchanges with the passenger.
- _____ will only use vehicles that have protective shields between passenger and driver.

- Patient must have a surgical mask and gloves.
- Driver will have goggles and gloves.
- Driver does not assist the patient in any way. Driver will remain in the front seat while the passenger enters and exits the vehicle.
- Upon passenger drop-off, driver will completely disinfect the entire passenger compartment using hospital-grade disinfectant.

Communications Plan

Point of Contact: _____

City will procure 7x two-way radios for use in the facility with two chargers (one for the decontaminated side of the facility and one for the contaminated side). Each of the following personnel will be issued a radio: 2x medical personnel, 2x security detail, 1x administrator/volunteer, 1x custodial staff, 1x reserved for MD or social worker. All parties will ensure positive communications at all times in the event of an emergency. Radio checks will be completed every hour on the hour.



Daily Schedule:

Time	Event	Personnel
6:30am	Patient wake-up/lights on	Med Staff #1 & #2
7:00am-7:30am	Shift Change	Admin Staff, Med Staff #1 & #2
7:00am-11:00am	Monitoring clients, meds dispensing as needed, etc.	Med Staff #1 & #2
7:30am	Breakfast/coffee available	Admin Staff, Med Staff #1 & #2
8:00am	Rounds and Med Dispensing	Med Staff #1 & #2
8:30am	Meal Clean-up	Custodial Staff
11:00am	Lunch	Admin Staff, Med Staff #1 & #2
12:00pm	Meal Clean-up	Custodial Staff
12:00pm-5:30pm	Health Monitoring, Showers (1 per patient per day)	Med Staff #1 & #2
3:00pm-3:30pm	Shift Change	Admin Staff, Med Staff #1 & #2
5:30pm	Dinner	Admin Staff, Med Staff #1 & #2
7:00pm	Meal Clean-up	Custodial Staff
7:00pm-10:00pm	Health Monitoring and Med Dispensing	Med Staff #1 & #2
11:00pm-11:30pm	Shift Change, Med Check, Lights Out	Admin Staff, Med Staff #1 & #2

Notes:

- Staff should take breaks as necessary as long as one medical staff is present to address patient needs at all times.
- Staff can eat meals in the administrative office located on the decontaminated side of the facility.
- Staff will be responsible for receiving and distributing food delivery via the protocol located in the “Food Plan” outlined in this document.

Supplies

Personal Items (i.e. hygiene items, electronics, etc)

Point of Contact - _____

Item	Quantity	Source	Confirmed (Y/N)
Laptops	15		
Headphones	15		
Books	100		
TVs	5		
Toothpaste	50		
Toothbrushes	50		
Soap	50		
Towels	50		
Sandals (for showers)	50		
Razors	50		
Shaving Cream	50		
Socks (ideally non-skid)	50		
Sweatshirts	50		
Sweatpants	50		
Underwear	50		
Shower Curtains	15		
Power charging stations (for cell phones/laptops)	5		
Cigarettes (?)	N/A		
Magazines	N/A		

Medical Supplies

Point of Contact - _____

Essential items are designated with **

Item	Quantity	Source	Confirmed (Y/N)
Forehead Infrared Thermometers**	2		
Wheelchair	2		
BP cuffs/Pulse Oximeters**	2		
Glucometer with lancets/strips**	1		
Remote AV Station (rolling carts with Tablets or Laptops for telemedicine)**	2		
Oxygen tank for emergency only until EMS arrives**	1		
Face mask with tubing for oxygen**	5		
AED**	2		
Naloxone Kit**	3		
First Aid Kit**	1		
Medication Refrigerator**	1		
Medication boxes	50		
Chux Pads	100		
Instaglucoase or glucose tabs**	5		
Stethoscope**	2		
Stretcher	1		
Body Bag	3		
Ambu Bag**	1		

5 | Clinical Workflow and Protocols

Daytime admissions to COVID19 Respite (8AM to 6PM)

Referring Facility Details

Shelter/respice	Shelter designates appropriate staff for verbal handoff to COVID respite facility. Patient requires COVID testing prior to transfer. Information required during handoff listed in Handoff Checklist
YNHH	MD will place a Social Work referral. SW should screen patient for housing insecurity, health insurance coverage and eligibility, and COVID respite admission eligibility criteria (please see Handoff Checklist)
VA or Cornell Scott	See “YNHH” above, via placing a Social Work referral.
Street Medicine Team	Team members can refer directly to COVID19 respite once testing for COVID19 has been performed and confirmed COVID (+).
Police/Other	COVID19 respite will not accept direct admissions from law enforcement. These patients should go through YNHH ED and receive a medical evaluation.

COVID Respite Details

- Admissions office staff will receive calls directly between 8AM and 6PM 7 days a week.
- Intake staff will review the Handoff Checklist with the referring provider to ensure it is complete and the patient is eligible for admission prior to accepting any transfers.
- If the administrator is unsure whether the patient is eligible for admission to COVID19 respite, they should discuss the case with their Manager or MD/APP on call.
- Identify appropriate location for new admission.
- Upon accepting the transfer, admissions office staff will notify on-call MD and staff RNs/CNAs.

COVID(+) Respite Referral Form

Date of referral:
Person making referral
Contact number
Facility making referral
Date client ready for discharge

Must obtain approval prior to admission/transfer. Admissions staff available 7 days a week (8AM and 6PM .

Client Name:	DOB:
SS:	Is client homeless? Y N
Where does client go for medical care:	
Most recent address before hospital admission:	
Usually resides at/near:	

Client Status

Patient is 18 yo or older:	Y N	Patient is on supplemental Oxygen:	Y N
Able to care for self (ADLs):	Y N	Consents to admission to respite:	Y N
Ambulatory:	Y N	Assistive Device:	Y N
Bowel & bladder continent:		Y N	
If N, please explain/describe:			
Any Skilled nursing needs*?		Y N	
If Y, please explain/describe:			

COVID19 testing status:

Date symptoms started:	
Date swab obtained:	Date of results:
If multiple tests, please explain:	

Hospital Discharge Checklist

This checklist should accompany the patient.

Estimated Length of Stay in Respite Care: _____

Items to Complete Prior to Discharge:

- 30-day supply of all patient medications including narcotics, insulin, glucometer testing strips and glucometer needles
- Wound care supplies if needed with explicit wound care instructions.
- Any assistive devices needed (i.e., wheelchair, walker, cane)
- Provide the client with a complete W-10

Medication List:

Medication	Dosage	Schedule	PRN	Stop Date (if applicable)

Follow-Up Appointments:

Provider	Date	Location	Time

Emergency Contact Information

Contact Name	Alt, Contact Name
Relationship	Relationship
Telephone #	Telephone #

Handoff Checklist

Person experiencing homelessness: <ul style="list-style-type: none"> • Arriving from CT shelter • If YNHH or VA, identified as experiencing homelessness by SW as defined by HRSA. 	Y N
Patient consents to admission to COVID-19 respite	Y N
Patient is 18yo or older	Y N
No O2 requirement/patient would meet criteria for home quarantine	Y N
Does the patient need assistance with ADLs?* (Eating, Bathing, Dressing, Continence, Using the restroom, Transferring) *If YES to need assistance with ADLs or need for skilled nursing, a patient is NOT eligible for admission to COVID-19 respite. For potential case by case admissions call on call MD	Y N

If Y to any of the above, the patient is not eligible

Additional Information

Health insurance coverage: If yes, what type: Medicaid; Medicare; Other _____	
List current patient medications: Blood pressure medications: Diabetes medications: Insulin: yes no Cholesterol medications: Diuretics: Psychiatric medications: Medications for Chronic Pain: Medication for Opioid Use Disorder: Other:	
Any daily care needs (e.g. wound care)? If yes, list: _____ If yes, is the patient able to perform care on their own? _____	
Does the patient have a known Substance Use Disorder?	Y N
Patients Primary Care MD: _____	

or

Does not have

Other relevant information:

Intake Checklist

Performed by CNA/RN

Temp:_____ HR:_____ RR:_____ PaO2:_____	
Do you have a fever? Y N	Y N
Do you have a cough? Y N	Y N
Do you feel short of breath?	Y N
Do you have any chest pain or pressure?	Y N
Do you have a sore throat?	Y N
Do you have muscle aches?	Y N
Do you have any vomiting or diarrhea?	Y N
What other symptoms do you have?	Y N
What health problems/medical conditions do you have?	
What medications do you take?	
Has a doctor ever prescribed you medications for: High blood pressure? If yes, _____ Heart failure? If yes, _____ High cholesterol? If yes, _____ Diabetes? If yes, _____ Chronic pain? If yes, _____ Your mood, anxiety or depression? If yes, _____	
Perform the Brief CAGE and MODIFIED MINI Questionnaire on all admissions – to be performed by behavioral health specialist (see APPENDIX)	[]
Review and sign Voluntary Isolation Form with all new patients All patients on the COVID-19 ward will be asked to read and sign a letter from the City stating the importance of voluntary isolation as they recover from COVID-19. Admitting staff should sign the form as well. Begin arranging disposition of patients and coordinate with patient’s case manager.	[]

Clinical Staff Roles

Certified Nursing Assistant (CNA) or Medical Assistant (MA)	<p>Complete intake screening form with client (<i>see below</i>)</p> <p>Vitals checks: Temperature, O2sat, HR, RR, and BP (only for individuals with history of hypertension)</p> <p>Narcan administration if needed.</p>
Registered Nurse (RN)	<p>Complete intake screening form with client (<i>see below</i>)</p> <p>Vitals checks: Temperature, O2sat, HR, RR, and BP (only for individuals with history of hypertension)</p> <p>Medication dispensing</p> <p>Symptoms check (<i>see below</i>)</p> <p>Narcan administration if needed.</p>
Behavioral Health Specialist (LCSW or Psychologist)	<p>Receive behavioral health referrals based on positive CAGE and Modified Mini Screens; evaluate, triage, and refer as appropriate (tele-visits).</p> <p>On-call for behavioral health issues and emergencies (available to come on site).</p>
Psychiatrist	<p>Consultation about medication management and behavioral health emergencies (telehealth)</p> <p>Intake tele-med visit for each patient</p> <p>Pre-discharge tele-med visit for each patient</p> <p>PRN tele-visits as indicated by RN or by patient request</p> <p>On-call for RN questions</p> <p>Participate in huddle/check in with on-site staff at each shift change (<i>see below</i>)</p> <p>Narcan administration if needed.</p>
MD/PA/APRN	<p>General management of the facility</p> <p>Take all admissions calls and screen referrals for eligible admissions</p> <p>Serve as the PPE Champion and monitor donning and doffing of staff at shift change</p>
Administrator/Manager	<p>Role to be determined by the city</p>
Security	<p>Role to be determined by the city</p>

Clinical Monitoring Protocols Levels

In this document we provide two different protocols for clinical monitoring: A “basic” protocol assuming minimal resources for clinical monitoring and a population at lower risk for rapid decompensation; and a second protocol, the “closer monitoring” protocol, that can be used if increased staffing is available and client population is deemed high risk for decompensation.

Workflow – Basic Monitoring Protocol

All Staff

Procedure for screening susceptible staff for COVID1:

All employees working in the COVID ward will be required to sign-in/sign-out at the beginning and end of their shift. There will be a thermometer in the Donning Area, and employees will record their temperature twice per day, at the start of shift and at the end of shift (see Appendix). Additionally all employees will review the following symptom check prior to entering the facility.

1. Do you have a fever, feel feverish or have chills? Yes/No
2. Do you have any lower respiratory symptoms:
 - a. Cough? Yes/No
 - b. Shortness of breath? Yes/No
 - c. Difficulty breathing? Yes/No

If temperature 100 degrees or greater or yes to any symptoms above: no admittance, 14 day home isolation. Please notify the site manager or supervisor.

Ref: Boston Health Care for the Homeless Program and Fair Haven Community Health Center

Procedures for PPE

All staff will complete official PPE training during orientation. Staff wear their PPE (gown, mask, face shield, double gloves) during their entire time on the ward, changing only their outer glove in between patients.

Donning/Doffing PPE (see Appendix): The COVID ward will use enhanced contact and droplet precautions for management of COVID positive patients and patients under investigation (PUI). All employees donning and doffing will do so with a “spotter” to ensure consistent and effective technique. We will utilize the most recent guidance from the Centers for Disease Control and Prevention regarding PPE and COVID-19. Donning will occur in the designated anteroom, and doffing will occur immediately prior to exiting the ward. All staff will don/doff in the anteroom closest to the administrative wing, unless in the case of an emergency, admission, transfer, or discharge.

Staff should plan to remain in the same set of PPE, unless it is soiled, for the duration of their time on the COVID ward. They should change outer gloves in between providing direct patient care.

Ref: Boston Health Care for the Homeless Program

Procedure for Trash Disposal

Trash (PPE, patient trash) that is non-hazardous should be placed in designated waste receptacles on the COVID ward making sure that these receptacles are not filled more than 3/4 of the way full.

When a receptacle is full the bag should be removed and tied using the 'gooseneck' technique. Care should be taken as to not manually compress the trash inside the receptacle.

The tied bag should be brought out the contaminated side of the ward and placed into the previously bagged mobile trash can in the designated location.

Ref: Boston Health Care for the Homeless Program

RN/CNA

For all patients	<p>On Admission</p> <ul style="list-style-type: none">▪ Perform the Intake Checklist and enter information into the EHR or paper chart▪ Confirm patient is assigned to the correct location within the facility (PUI asymptomatic; PUI symptomatic; COVID-19+ test) <p>Schedule Tele-medicine visit with MD within 12 hours of admission</p> <p>On Discharge</p> <ul style="list-style-type: none">▪ Notify SW of planned discharge >24 hours in advance▪ Confirm plan for shelter after discharge▪ Schedule Tele-medicine visit with MD 12 hours prior to discharge▪ Review medication reconciliation and follow up telemedicine visit plan
Start of shift	<p>Participate in virtual team huddle</p> <p>-Daily patient check in:</p> <p>-Do you feel better, worse, or the same as the day before?</p> <p>-Do you have any new symptoms?</p> <p>-If a patient reports worsening symptoms:</p>
Shift tasks	<p>-Vitals screening (O2sat+temperature+RR+HR) on any patients reporting worsening symptoms and ask symptoms check questions</p> <p>-Do you have a cough?</p> <p>-Do you feel short of breath or have difficulty breathing?</p> <p>-Do you have any chest pain?</p> <p>-What other symptoms do you have?</p> <p>If ANY abnormal vitals sign or worsening symptoms follow the Escalation of Care protocol AND notify on call MD.</p>

	<ul style="list-style-type: none"> -Review scheduled patient list for scheduled medications -Provide patients with medication boxes -Collect boxes and return to locked area -Respond to any patient needs for PRN medication or supplies -Respond to any patient concerns -Document vitals, symptoms, medications provided and all other relevant information in patient chart
End of shift	-Participate in team huddle – complete Shift Change Checklist
Patients will administer their own medications including insulin. Patients will be responsible for personal wound care (see “Special Populations”)	
MD/APRN/PA	
For all patients	<p>On Admission</p> <ul style="list-style-type: none"> ▪ Confirm patient is assigned to the correct location within the facility (PUI asymptomatic; PUI symptomatic; COVID-19+ test) ▪ Tele-medicine visit with patient within 12 hours of admission ▪ Review medications and PMHx, if needed prescribe medications to be picked up at nearby pharmacy ▪ Perform screening for OUD and prescribe/start buprenorphine and/or methadone (see “Substance Use Disorder Protocol”) <p>On Discharge</p> <ul style="list-style-type: none"> ▪ Review plan for shelter after discharge with patient and SW ▪ Discuss care needs after discharge with RN, SW and patient ▪ Tele-medicine visit with patient 12 hours prior to discharge ▪ Review medication reconciliation and follow up telemedicine visit plan
Round with staff Q shift: Review census, anticipated discharges/admissions	
Narcan: All staff will be provided with Narcan training	
Workflow for administrative staff	
For all patients	<p>On Admission</p> <ul style="list-style-type: none"> -Dispense daily itinerary/schedule, blankets, towels, soap, trash bags, gloves, masks -Orient to rules, expectations, facilities

Workflow - Closer Monitoring Protocol

All Staff

Procedure for screening susceptible staff for COVID₁:

All employees working in the COVID ward will be required to sign-in/sign-out at the beginning and end of their shift. There will be a thermometer in the Donning Area, and employees will record their temperature twice per day, at the start of shift and at the end of shift (see Appendix). Additionally all employees will review the following symptom check prior to entering the facility.

1. Do you have a fever, feel feverish or have chills? Yes/No
2. Do you have any lower respiratory symptoms:
 - a. Cough? Yes/No
 - b. Shortness of breath? Yes/No
 - c. Difficulty breathing? Yes/No

If temp 100 degrees or greater or yes to any symptoms above: no admittance, 14 day home isolation. Please notify the site manager or supervisor.

Ref: Boston Health Care for the Homeless Program and Fair Haven Community Health Center

Procedures for PPE₁

All staff will complete official PPE training during orientation. Staff wear their PPE (gown, mask, face shield, double gloves) during their entire time on the ward, changing only their outer glove in between patients.

[YNHH Training Video](#)

Donning/Doffing PPE (see Appendix): All employees donning and doffing will do so with a “spotter” to ensure consistent and effective technique. We will utilize the most recent guidance from the Centers for Disease Control and Prevention regarding PPE and COVID-19. Donning will occur in the designated anteroom, and doffing will occur immediately prior to exiting the ward. All staff will don/doff in the anteroom closest to the administrative wing, unless in the case of an emergency, admission, transfer, or discharge.

Staff should plan to remain in the same set of PPE, unless it is soiled, for the duration of their time on the COVID ward. They should change outer gloves in between providing direct patient care.

Ref: Boston Health Care for the Homeless Program

Procedure for Trash Disposal

Trash (PPE, patient trash) that is non-hazardous should be placed in designated waste receptacles on the COVID ward making sure that these receptacles are not filled more than 3/4 of the way full.

When a receptacle is full the bag should be removed and tied using the 'gooseneck' technique. Care should be taken as to not manually compress the trash inside the receptacle.

The tied bag should be brought out the contaminated side of the ward and placed into the previously bagged mobile trash can in the designated location.

RN/CNA

For all patients

On Admission

- Perform the Intake Checklist and enter information into the her
- Schedule Tele-medicine visit with MD within 12 hours of admission

On Discharge

- Notify SW of planned discharge >24 hours in advance
- Confirm plan for shelter after discharge
- Schedule Tele-medicine visit with MD 12 hours prior to discharge
- Review medication reconciliation and follow up telemedicine visit plan

Start of shift

Participate in team huddle

First 2 hours of shift

- Vitals screening (O2sat+temperature+RR+HR) on all patients
- Symptoms check on all patients
- Are your symptoms the same, better, or worse than yesterday?
- Do you have difficulty breathing?
- Do you have any chest pain?
- What other new symptoms do you have?

If ANY abnormal vitals sign or worsening symptoms follow the Escalation of Care protocol AND notify on call MD.

Remainder of shift

- Repeat vital signs and symptoms check on ALL symptomatic patients mid-shift (except overnight shift)
- Review scheduled patient list for scheduled medications
- Provide patients with medication boxes
- Collect boxes and return to locked area
- Respond to any patient needs for PRN medication or supplies
- Respond to any patient concerns

	<ul style="list-style-type: none"> Document vitals, symptoms, medications provided and all other relevant information in patient chart
End of shift	Participate in team huddle – complete Shift Change Checklist
Patients will administer their own medications including insulin. Patients will be responsible for personal wound care.	
MD/APRN/PA	
For all patients	<p>On Admission</p> <ul style="list-style-type: none"> Tele-medicine visit with patient within 12 hours of admission Review medications and PMHx, if needed prescribe medications Perform screening for OUD and prescribe/start buprenorphine and/or methadone <p>On Discharge</p> <ul style="list-style-type: none"> Review plan for shelter after discharge with patient and SW Discuss care needs after discharge with RN, SW and patient Tele-medicine visit with patient 12 hours prior to discharge Review medication reconciliation and follow up telemedicine visit plan
Round with staff Q shift: Review census, anticipated discharges/admissions	
Narcan: All staff will be provided with Narcan training	
Administrative Staff	
For all patients	<p>On Admission</p> <ul style="list-style-type: none"> Dispense daily itinerary/schedule, blankets, towels, soap, trash bags, gloves, masks Orient to rules, expectations, facilities

Shift Change Checklist

Oncoming and Off-going RN, CNA, SW and on call MD will participate at all change of shift

Off-going staff to identify

- **What clinical concerns do you have for specific patients?**
 - **Illness Severity**
 - **Patient Summary**
 - **Action List**
 - **Situational Awareness and contingency planning**
 - **Summary by the receiver**
- **Review any issues that arose during the shift.**
- **Anticipate any issues for the oncoming shift.**
- **Review any anticipated transfers/admissions.**
- **Review any anticipated discharges.**

Oncoming staff

- **Each person on the team identifies self and role for the upcoming shift.**
- **What questions do you have for the team?**
- **Review the Escalation of Care Protocol at the start of EACH shift and assign roles in the event of a Code Blue**

Escalation of Care Protocol

IF a patient reports **chest pain/pressure**, please take a full set of vitals and alert the on call MD/APRN to initiate a telemedicine visit.

For **new or worsening symptoms**, take a full set of vitals (Temp, HR, BP, RR, O2sat) and calculate the Modified Early Warning (MEW) score, then alert on call MD/APRN, initiate telemedicine visit.

MEW Score (IF =>2 call on call MD/APP):

Systolic BP? (mmHg)

=<70 (3 points)

71-80 (2 points)

81-100 (1 point)

101-199 (0 points)

=>200 (2 points)

_____ points

Heart Rate? (BPM)

=<40 (2 points)

41-50 (1 point)

51-100 (0 points)

101-110 (1 point)

111-129 (2 points)

=>130 (3 points)

_____ points

Respiratory Rate?

<9 (2 points)

9-14 (0 points)

15-20 (1 point)

21-29 (2 points)

=>30 (3 points)

_____ points

Temperature?

<35 C / 95 F (2 points)

35-38.4C / 95 - 101.2F (0 points)

=>38.5 C / 101.3 F (1 point)

_____ points

Neurological Score?

<p>Alert (0 points)</p> <p>Reacts to Voice (1 point)</p> <p>Reacts to Pain (2 points)</p> <p>Unresponsive (3 points)) _____ points</p> <p style="text-align: right;">Total: _____ points</p>
<p>For SEVERE symptoms (<i>see below</i>), arrange for transfer to YNHH (call 911)</p>
<p>Severe Symptoms:</p> <p>If ANY of the following present, call 911 immediately</p> <ul style="list-style-type: none"> • Extremely difficult breathing • Conversational dyspnea (patient cannot speak in full sentences) • Bluish lips or face • Severe persistent dizziness or lightheadedness • Confusion, inability to arouse, change in mental status • Seizures • Oxygen saturation <90%
<p>CODE BLUE Protocol:</p> <ul style="list-style-type: none"> • Call for help and 911 • For patients with diabetes – consider checking a blood sugar • Consider Narcan administration • If unconscious, no pulse or not breathing initiate BLS with AED until Emergency Medical Team arrives • ***Of note, only providers donned in appropriate PPE and well trained should administer CPR <p>CODE BLUE Advanced Protocol: This protocol was shared by the Boston Health Care for the Homeless Program COVID respite program. Their respite program had a different physical set up and staffing and is largely not applicable to most COVID respite programs. (see Appendix)</p>

Contingency Protocols: Previously Asymptomatic Dorm/Hotel Based Client Reports New Symptoms Concerning for COVID

Key Assumptions:

Testing

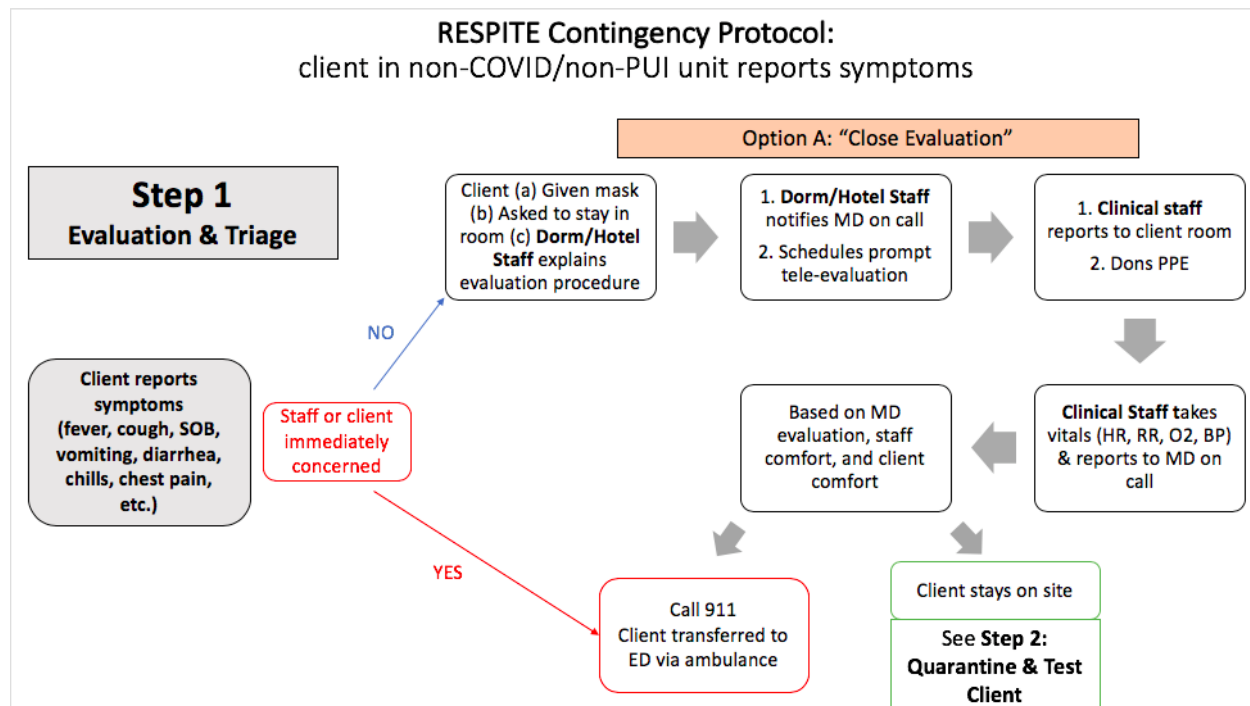
- Rapid Testing: Access to YNHH rapid testing (ie. testing results in < 24 hours)
- Non-Rapid Testing: Testing sent to private lab and/or city lab with 3-7 day result turn around

Locations/Facilities

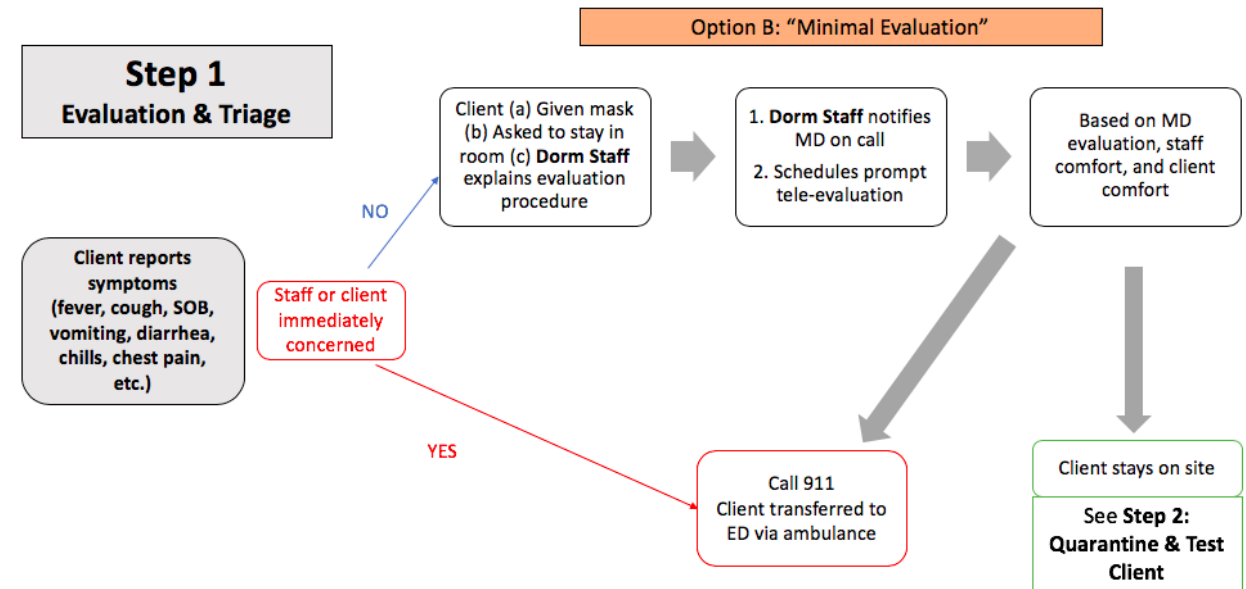
- *** This protocol makes key assumptions about COVID respite facilities that are currently not in place as of April 2020. Primarily it assumes there is a separate COVID+ and COVID PUI unit. Currently there is only a COVID+ unit.
- Clients awaiting testing results can quarantine in their designated room (ie. do not require transfer to a PUI ward or COVID + unit)

Roommates

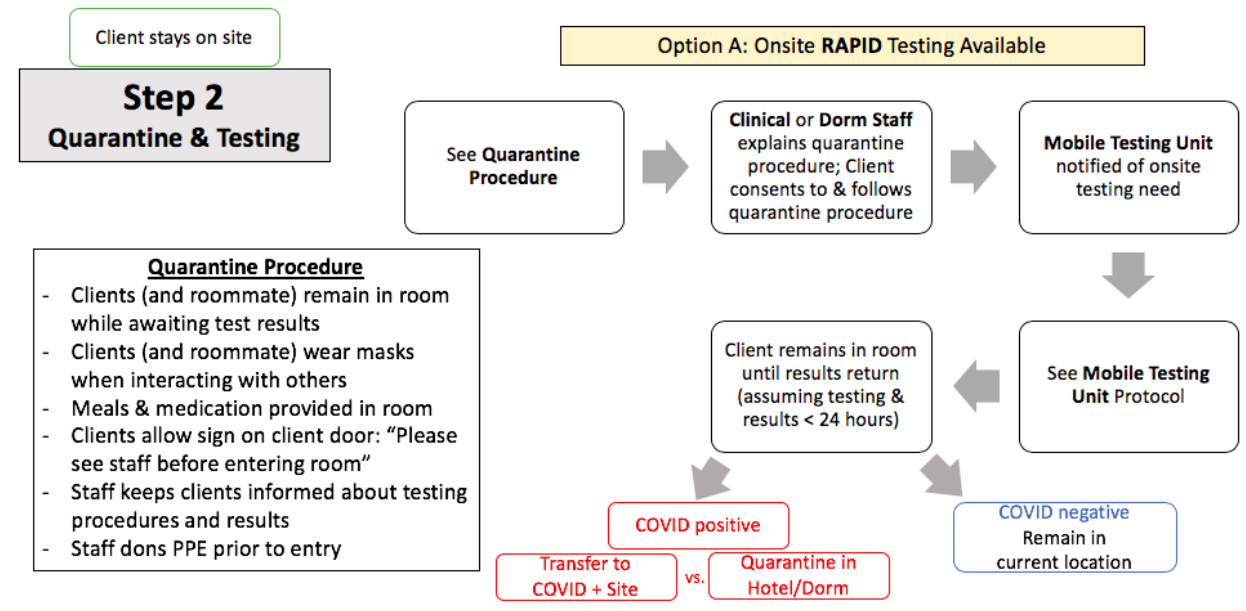
If client with symptom has a roommate, roommate will be moved into a separate room; testing protocol will apply to roommate as well since they have been exposed, regardless of symptoms



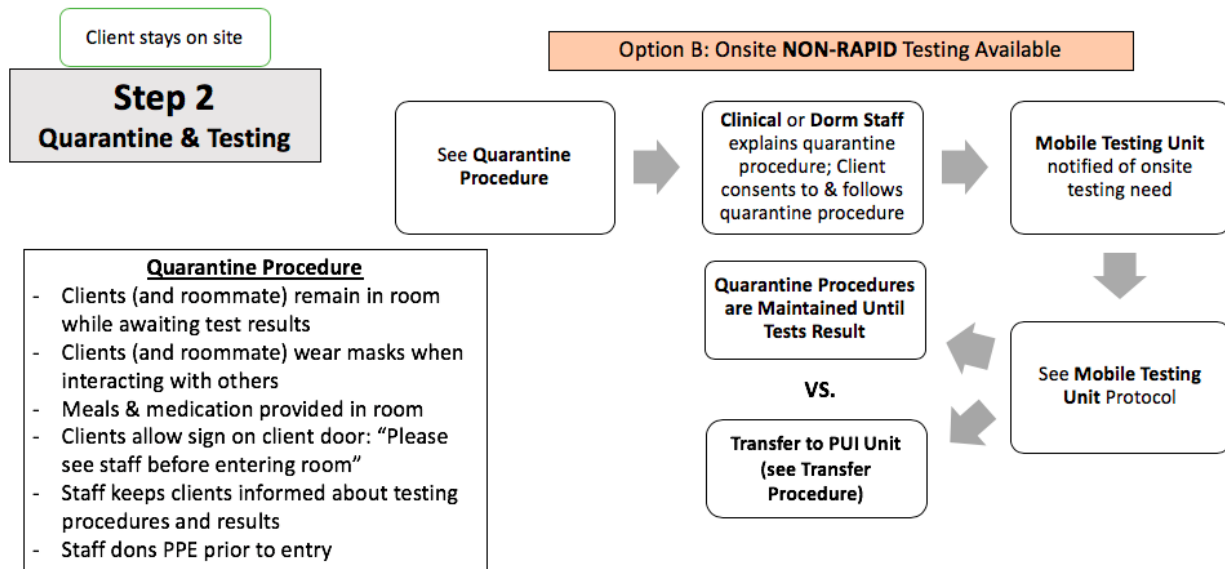
RESPIRE Contingency Protocol:
client in non-COVID/non-PUI unit reports symptoms



RESPIRE Contingency Protocol:
client in non-COVID/non-PUI unit reports symptoms



RESPITE Contingency Protocol: client in non-COVID/non-PUI unit reports symptoms



RESPITE Contingency Protocol: client in non-COVID/non-PUI unit reports symptoms

Mobile Unit Onsite Testing Protocol – Resources Needed

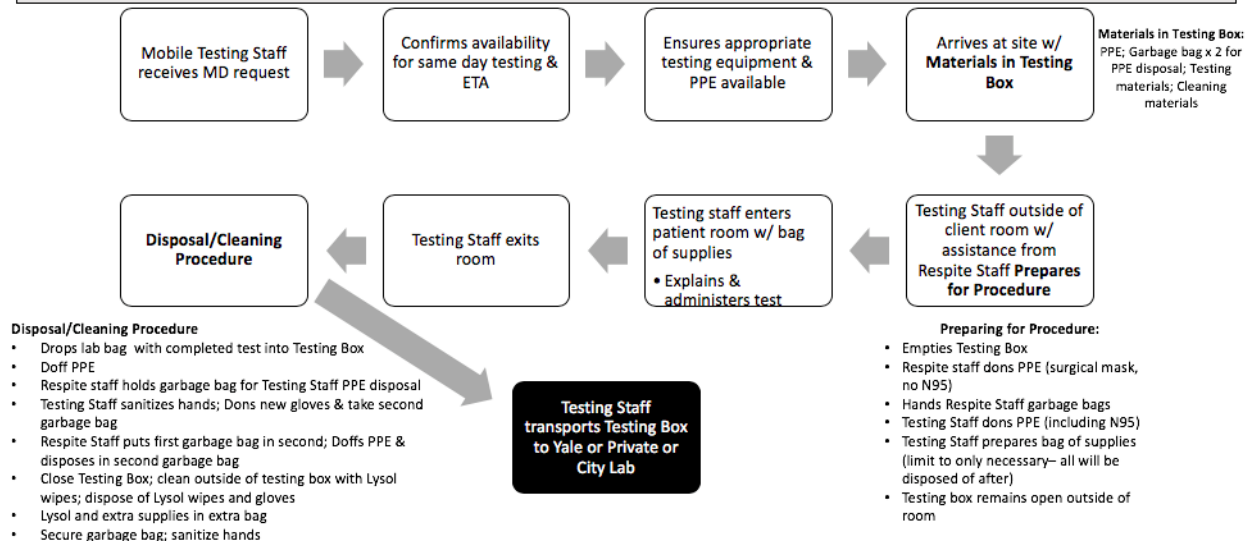
Testing Materials (per test)

- 3 x set of PPE available for each encounter (2 to use, 1 extra; including 1 N95 and 2 surgical masks)
- Testing Materials: NP/OP swab, Lab bag
- Transport Box
 - Must be large enough to fit all supplies
- Extra bag for transport
- Disinfecting wipes
- 5 sets of gloves (3 to use, 2 extra)
- Hand sanitizer



RESPITE Contingency Protocol:
client in non-COVID/non-PUI unit reports symptoms

Mobile Unit Onsite Testing Protocol – Flowchart Form



RESPITE Contingency Protocol:
client in non-COVID/non-PUI unit reports symptoms

Protocol for Transferring a Patient to a COVID + Ward or Persons Under Investigation Ward

Transport Vehicle Options:

- Off-Service Yale Shuttle
- Off-Service Senior Transport Car/Van

Testing Staff Options:

- YNHH Staff
- Respite Staff
- Volunteer Staff

Transport Protocol:

Prior to Transport

- Follow Quarantine Protocols as detailed above

Transport

- Client: wears mask; does not touch surrounding environment; remains > 6 ft from others; transports own belongings
- Respite Staff dons PPE for transport
- **Dorm Staff** or **Security** maintain 6 ft and assist with escort

Client arrives at PUI dorm or COVID + Dorm

- Respite staff completes:
 - PUI vs. COVID intake form
 - PUI vs. COVID orientation

Vehicle Cleaning

- Determined by city

Medication Distribution Protocol:

- All client medications will be stored in a locked closet in individual medication boxes.
- During intake client will give staff all prescription and over the counter medications to store for the remainder of their stay
- All medications will be labeled with the client's name and the medication contents.
- Clients may only take medications prescribed an in their own medication box
- Respite Staff will record distribution of medications in a medication log.
- If clients require refills or new medication prescriptions the on-call doctor will be notified who will either be in touch with the client's PCP or prescribe the relevant medications

Notes on Specific Medical Problems

Wound Care	Staff should be made aware of all patients with open wounds on intake. However, patients will need to perform care and maintenance of their wound(s) independently, including dressing changes. Staff is capable of labeling and securing patients' wound care supplies in the medication room and will provide them to the patient upon request. Patients connected to visiting nursing services for wound management will be allowed to continue with these services at the facility as deemed appropriate by staff at the facility and the visiting nursing organization.
Injectable Medications	The use of injectable medications does not exclude patients from admission to the respite facility, but all injectable medications other than insulin (i.e. IM naltrexone, IM psychotropics) will need to be discussed and approved by the MD/APRN/PA on admission to ensure staff will be able to administer such medications as prescribed by outside providers. Patients using insulin will be responsible for managing the time and dosing of their insulin as they would outside of the respite facility. Patient's insulin and injection supplies will be labeled and stored in the medication room and made available to patients upon request.
Blood Sugar Monitoring	As with insulin, patients will be asked to adhere to their needs to monitor their blood sugar independently and as they would outside of the respite care facility. Though staff should be made aware of patients who monitor their blood sugar, finger-stick glucose monitoring must be initiated by patients. Supplies will be provided upon request.
Blood Pressure Monitoring	Blood pressure monitoring will not occur unless patients have been identified to have unstable hyper- or hypotension. Patients who desire more frequent monitoring will need to request such.

Behavioral Health Protocols

Staff

<p>Social work on site daily</p>	<p>Perform the CAGE Questionnaire and Modified Mini Screen on all admissions, with escalation to behavioral health specialist as necessary</p> <p>Arrange disposition with patient's existing case manager or assist with assignment of a new case manager</p>
<p>Behavioral Health Specialist (LCSW/psychologist)</p> <p>*depending on staffing availability, role may need to be covered by different providers*</p> <p>on call off site 24 hr, available to come on site;</p>	<p>Workflow</p> <ul style="list-style-type: none"> ▪ Social work (administrative staff) should call for positive CAGE and Modified Mini Screens on admission ▪ Other staff may call for routine mental health issues ▪ Psychiatrist can determine need for in-person evaluation by the behavioral health specialist during a behavioral health emergency <p>Responsibilities</p> <ul style="list-style-type: none"> ▪ Receive behavioral health referrals based on positive CAGE and Modified Mini Screens; evaluate, triage, and refer as appropriate (tele-visits). Complete Columbia Suicide Screen on admission PRN. ▪ Routine mental health concerns; call on call psychiatrist as needed ▪ Liaise with current outpatient treaters if applicable ▪ Linkage to outpatient mental health treatment upon discharge as needed ▪ Available to come on site if needed for behavioral health issues and emergencies
<p>Psychiatrist:</p> <p>*depending on staffing availability, role may need to be covered by different providers*</p> <p>On call off site 8a-10p</p>	<p>Workflow:</p> <ul style="list-style-type: none"> ▪ Behavioral health specialist or medical provider can reach out to psychiatrist on call directly as needed for phone consultation ▪ Will advise remotely about medication refills, changes, or initiations, but on-site medical provider will be the prescriber <p>Responsibilities:</p> <ul style="list-style-type: none"> ▪ Behavioral health emergencies- guidance over the phone; does not come on site. No emergency meds available - treat as outpatient emergency with escalation to 911, involve behavioral health specialist on call or mobile crisis as needed ▪ Assist on site medical provider with outpatient medications – continuation, changes, or initiations; by phone consultation, with telehealth visit with patient as appropriate ▪ Assist behavioral health specialist with routine evaluations, transitional treatment ▪ Liaise with current outpatient providers if applicable

On admission

On admission, the CAGE questionnaire and Modified Mini Screen (see Appendix C) will be administered by social worker to all patients in a private area. Will ensure client understands all questions and provide explanation as needed.

CAGE questionnaire	Answering yes to any of these questions indicates possible substance use disorder. These patients should be referred for further evaluation by the behavioral health specialist (LCSW or psychologist), with referral to psychiatrist as needed.
Modified Mini Screen	<p>See instrument in Appendix C. To score, total the number of “yes” answers to determine if further assessment is needed by the behavioral health specialist on call. Based on the responses and clinical history, the behavioral health specialist will determine need for further assessment or interventions, including consultation with on call psychiatrist.</p> <p>Score ≥ 10, assessment is needed</p> <ul style="list-style-type: none">▪ Score ≥ 6 & ≤ 9, assessment may be needed, determined by behavioral health specialist▪ Score < 5, no action necessary▪ If “yes” response to #4 (suicidal), urgent assessment is needed by behavioral health specialist with completion of Columbia Suicide Screen▪ If “yes” responses to #14 and #15 (trauma), assessment is needed

Routine mental health problems

Patients with existing provider	<ul style="list-style-type: none">▪ Behavioral health specialist should assist the patient in reaching out to patient’s own mental health provider/clinician for medication refills, tele-health visits, and scheduling follow-up appointments as appropriate.▪ May call the on call psychiatrist as needed for advice regarding outpatient medications or need for further assessment.
Patients without existing provider	<ul style="list-style-type: none">▪ Behavioral health specialist will assist with evaluation, transitional treatment, and a community referral for further mental health treatment.▪ May call the on call psychiatrist to discuss their evaluation, medications, and need for further diagnostic evaluation. If applicable, medical provider will prescribe the recommended medications.▪ The patient’s long term case manager in the community should assist in ensuring follow up with mental health treatment after discharge.

Behavioral health emergencies

Behavioral health emergencies include any agitation, expressed thoughts or actions threatening to harm self or others, or any other acute behavioral changes suspected to be caused by a mental health condition.

For a behavioral health emergency, any staff should call the psychiatrist on call for consultation. Decisions will aim to primarily protect the safety of patients and staff, while keeping in mind PPE use.

Direction may include:

- Advice on how to further evaluation and de-escalate verbally with advice for future safety planning

- Involving an on call behavioral health specialist to perform an on site evaluation (with appropriate PPE)
- Asking for NHPD security detail for assistance
- Calling 911 for police and ambulance transport to hospital emergently. Must inform hospital of transport given patient's COVID+ status.
- Calling mobile crisis (via 211) for 24/7 mental health clinician guidance with potential to dispatch a provider.

Discharge Criteria:

Per [CDC Guidelines](#) as written below. Of note the CDC indicates that these timelines might be extended for individuals who would be discharged to a congregate living facility – discharge timelines will likely occur on a case to case basis. Please always check for most up to date [CDC Guidelines](#).

COVID-19+ patients with symptoms	At least 3 days (72 hours) have passed since recovery defined as resolution of fever without the use of fever-reducing medications and Improvement in respiratory symptoms and At least 7 days have passed since symptoms first appeared
COVID-19+ patients without symptoms	At least 7 days have passed since the date of their first positive COVID-19 diagnostic test and have had no subsequent illness provided they remain asymptomatic For three days following discontinuation of isolation, persons should continue to limit contact and limit potential of dispersal of respiratory secretions by wearing a covering for their nose and mouth when in settings where other people are present
Symptomatic patients without a test	At least 3 days (72 hours) have passed <i>since recovery</i> defined as resolution of fever without the use of fever-reducing medications and improvement in respiratory symptoms (e.g., cough, shortness of breath); and At least 7 days have passed since symptoms first appeared
Symptomatic patients who require a higher level of care	Mental health symptoms requiring inpatient psychiatric admission Aggressive or non-cooperative behavior Sudden withdrawal from alcohol or opioids
Patients who violate the rules of respite	See rules of respite

After Visit Summary

A written After Visit Summary (AVS) will be provided to the patient upon discharge.

1. Copies will be made and provided to the individual's medical provider and/or future care setting with permission from the patient.
2. On-duty RN or MD will verify that the patient understands the AVS and will answer questions
3. Social Worker will assess the individual's needs at this time and follow-up as needed.

6 | Caring for people using non-prescribed drugs

These protocols are based on guidance from [Yale Addiction Medicine](#) and [Vancouver Coastal Health](#)

Why is this important?

These emergency shelters are specifically designed to keep New Haven's most vulnerable community members safe during the COVID 19 pandemic / public health emergency. Therefore, our goal is to support guests to be able to follow guidelines for isolation and quarantine. This requires flexibility and creativity from service providers, as well as possibly reframing approaches to care currently used in shelter or healthcare settings. *For example, some shelters have a policy of refusing services to people who are actively using drugs. This is not feasible or logical in this setting, since it would not align with the goal of supporting this individual to maintain isolation/quarantine to stay healthy, safe and prevent spread of COVID 19.* If the goal is to have people stay in place, we need to be asking people up front "What do you need to be able to stay here for 2 weeks safely / sanely?" and doing what we can to make that possible so that people can stay alive and healthy.

Guiding Principles: [see above](#)

Initial screening for current non-prescribed drug use and treatment for non-prescribed drug use:

- Screening for non-prescribed drug use must be clearly non-punitive. Our goal is to build trust and foster honesty so we can provide a safe care environment for guests. At the same time we understand that people might not be able to be honest given current punitive systems, perceived/actual risk for incarceration, trauma history.
- No breathalyzer or drug testing is necessary for entry to these facilities, people can access them regardless of sobriety as long as they are not violent to themselves or others
- Staff will support guests who are intoxicated when they arrive: providing space, redirection, counseling etc. and containing risk to other people and preventing use of force by security
- Violence towards staff or other guests is not tolerated and staff / volunteers will use their judgement to initiate and mediate between off-site behavioral health teams and security.
- Behavioral health teams must consider if respite setting is appropriate setting or if a higher level of care is needed.

Screening Questions:

1. Are you receiving treatment for non-prescribed drug use? What medications are you prescribed?

- Teleworking psychiatric prescriber collaborates with community providers and continues daily medications as prescribed (based on respite medication administration protocols):

<i>Alcohol Use Disorder</i>	<i>Benzodiazepines</i>	<i>Opiate Use Disorder</i>	<i>Nicotine</i>	<i>Cocaine</i>
<ul style="list-style-type: none">- Naltrexone- Gabapentin- Disulfiram		<ul style="list-style-type: none">- Suboxone- Methadone	<ul style="list-style-type: none">- NRT- Wellbutrin- Chantix	<ul style="list-style-type: none">- Topamax- Disulfiram- Wellbutrin

2. Do you use any non-prescribed drugs:

- Alcohol (use screening tool to assess dependence such as CAGE)
- If yes:
 - When was your last drink?
 - Any history of complicated withdrawals?
 - If at high risk for complicated withdrawal, consider transfer to psych facility that has capacity to safely monitor
 - Also see recommendations from [Street Medicine Institute's COVID 19 guide re: alcohol withdrawal \(page 10\)](#)
 - If low risk, consider working with psychiatry for managed withdrawal
- Nicotine-containing products (cigarettes, cigars, vapes etc)
 - Screen for willingness to use NRT/wellbutrin/chantix
 - If yes, prescribe these medications
 - If no, provide cigarettes and regular availability of smoking breaks
- Cannabinoids: no clear decision has been made about use in the facility
- Stimulants:
 - consider treatment /safer supply options based on shared decision making with guest (refer to chart of non-FDA approved medications with evidence for efficacy in cocaine and or stimulant use on page four of [this document from Office of Addiction Services and Support of New York State](#))
- Opiates: Heroin, fentanyl, opioid pills
 - Offer short or long term MAT including
 - Continuing or Quick-start suboxone
 - Methadone which will be provided in collaboration with local clinic

7 | Client Rights and Responsibilities

(Ref: Columbus House)

Client Rights:

All individuals requesting services from COVID19 Respite shall receive the Statement of Client Rights as part of the intake and initial orientation process. Said statement shall conform to all applicable regulations issued by State, Federal and other funders; and shall include, but not be limited to:

1. To be treated with dignity and respect, assuring privacy and autonomy and honoring differences.
2. The right to services in a humane setting with the least restrictive environment possible.
3. To be free from physical, sexual, verbal and emotional abuse.
4. To be free from financial or other exploitation, retaliation humiliation and/or neglect.
5. To be free from discrimination based on religion, race, color, creed, sex, sexual orientation, gender identity/expression, national origin, age, lifestyle, physical, mental or developmental disability, or the inability to pay for services. Not to be denied admission or separated from members of your family based on any of these things.
6. To decide for yourself who is a member of your family and to be served together with those people whether your family includes adults and children or just adults, or the age, disability, marital status, actual or perceived sexual orientation, or gender identity of any member of your family.
7. To be free from unnecessary or excessive medication, restraint or seclusion.
8. The right to be informed of and refuse any unusual or hazardous treatment procedures
9. The right to be advised of and to refuse observations by techniques such as one-way mirrors, tape recorders, televisions, movies, or photographs.
10. The right to be fully informed of all rights and to have an investigation and resolution into any alleged infringements of rights.
11. To be informed of one's own condition, of proposed or current services, treatment or therapies, and of the alternatives.
12. The right to consent to or refuse any service, treatment, or therapy with a full explanation of the expected consequences of such consent or refusal.
13. To be placed into a program based on the gender with which you identify.
14. To have a current, written, individualized service plan that addresses one's own mental health, physical health, social and economic needs, and that specifies the provision of appropriate and adequate services, as available, either directly or by referral.
15. The right to active and informed participation in the establishment, periodic review, and reassessment of the service plan.
16. The right to get services that meets your needs with a focus on helping you to get and keep permanent housing and achieve the things that are important to you.
17. Access to information pertinent to and in sufficient time to facilitate decision making.

18. To have all personal information and records kept confidential. To have information shared only when a release of information is approved by you or is allowed by other legal or governmental statutes and to have such conditions explained to you.
19. The right to informed consent, refusal or expression of choice regarding service delivery, release of information, concurrent services and composition of service delivery team.
20. To access or be referred to legal entities for appropriate representation, self-help support services and advocacy services.
21. To participate in any appropriate and available agency services, regardless of refusal of one or more other services, treatment, or therapies or regardless of relapse from earlier treatment in that or another service, unless there is a valid and specific necessity which precludes and/or requires your participation in other services. This necessity shall be explained to you and written in your current service plan.
22. To consult with independent treatment specialist or legal counsel, at one's own expense.
23. To receive services that is consistent with the Housing First model.
24. If you are a participant in a tenant-based rental assistance program, you have the right to choose the housing unit you will live in and to move within the CT BOS CoC area when your lease expires. All housing units must meet HUD standards, and you may be directed to a smaller geographic area, if necessary, to ensure that you can get services, unless that would put you at likely threat of violence or stalking.
25. To access one's own psychiatric, medical or other treatment records, unless access to particular identified items of information is restricted for clear treatment reasons.
26. To make suggestions and complaints about services.
27. To receive prompt and reasonable responses to requests and complaints.
28. To be informed of the reasons for discontinuance or denial of services in writing.
29. To have the opportunity to appeal decisions of discontinuance or denial of services and to receive written notification of the final decision.
30. To have oral and written instructions for filing a grievance.
31. To exercise any and all rights without reprisal in any form including continued and uncompromised access to services.
32. The right to know the cost of services.
33. To receive a copy of these rights and to have someone review them with you upon admission and annually thereafter.

Client Responsibilities:

1. Actively participate in your rehabilitation and help to develop your plan of care with a Columbus House staff member.
2. Take part in planning and participating in your own psychosocial rehabilitation program and provide information concerning your mental health and medical history.
3. Attend scheduled unit meetings and to select the unit of your choice to participate in.
4. Contact COVID19 Respite staff if you are going to be absent from the program. Cancel your transportation, if applicable, as soon as you know you will be unable to attend the program.

5. Ask a question(s) when you do not understand what is happening to you.
6. Let a Client of the staff know when you have a problem or feel sick.
7. Show respect for the property and rights of others.
8. Obey the laws which apply to all citizens.
9. Be familiar with and observe the rules and policies of COVID19 Respite.
10. Accept responsibility for your actions.
11. Cooperate with the goal of achieving self-sufficiency in the management of your everyday living.
12. As a COVID19 Respite you have a guaranteed right to a place to come, a guaranteed right to meaningful relationships, a guaranteed right to meaningful work and a guaranteed right to a place to return.

8 | Position Descriptions:

v1 3/26/20

City of New Haven COVID19 Respite Aide, Multiple shifts

Hours: Full-time, 40 hours per week,

Days 7a-3:30pm and every other weekend/holiday

Evenings 3pm-11:30pm and every other weekend/holiday

Nights 11p-7:30a

Job Summary:

The Respite Aide (CNA or MA) is an important and integral part of the nursing department at the COVID19 Respite unit. The purpose of the position is to provide the highest quality care to the COVID19 respite patients by collaborating with the team RN.

With direction from the team RN, the Respite Aide will offer clinical support services to the patients and will offer assistance and support to the team RN. These duties are essential to the overall functioning of the Respite unit. The position is crucial to assure the continuity of patient care, providing an essential link for communication involving all departments.

Responsibilities:

Under the direction of the team RN, the Respite Aide performs a variety of appropriately delegated patient care interventions. Each Respite Aide is responsible for the ward.

- Treats patients in a manner that preserves and supports patient confidentiality, patient rights, and patients dignity; Act as a member of the team of caregivers.
- Collaborates with the team RN throughout the shift to help facilitate the respite schedule; determines appropriate work assignments and priorities, as well as communicating the status of delegated task completion and outcome of patient data findings.
- Maintains timely ongoing verbal communication to the team RN in order to assure good patient care and the effective running of the ward.
- Assists nurse/provider during complex assessments, including observing RN with donning/doffing appropriate Personal Protective Equipment (PPE).
- Accurately collects requested patient data (e.g. vital signs, weights and reason for visits), notifying the team RN of abnormalities.
- Check inventories on a daily basis, communicates with Operational manager to order clinic supplies and stock them in their appropriate location upon arrival in order to avoid a shortage or misplacement of

necessary supplies

- Maintains appropriate equipment logs and records per standards; Copying, faxing and filing as needed

Qualifications:

- Comfort donning/doffing PPE (N95, Gown/gloves, Face mask)
- Medical terminology; Vital signs
- Behavioral health experience preferred
- Proficient reading and writing skills in English; Excellent communication and customer service skills
- High School Diploma or Equivalent required
- Minimum of two years' experience as a Nursing Assistant or Medical Assistant; Current certification as a Certified Nursing Assistant (CNA), successful completion of a Medical Assistant (MA) program
- Life support training certification (e.g. CPR, BLS, ACLS) from a course that includes a hands-on, in-person component. If not certified prior to the start date, applicant must submit certification within 60 days of the start date.
- Naloxone trained preferred
- AED trained; Experience in a Medical environment preferred

City of New Haven COVID19 Respite RN, Multiple shifts

Hours: Full-time, 40 hours per week,

Days 7a-3:30pm and every other weekend/holiday

Evenings 3pm-11:30pm and every other weekend/holiday

Nights 11p-7:30a

This position provides daily nursing support for COVID19 respite patients with responsibilities for patient assessment.

Responsibilities:

- Direct nursing care of patients on assigned team to ensure that all needs of the patients are met, in conformance with respite established policies and procedures, as well as Department of Health rules and regulations.
- Treats patients in a manner that preserves and supports patient confidentiality, patient rights, and patients dignity; Act as a member of the team of caregivers
- Collaborates with the Respite Aide throughout the shift to help facilitate the respite schedule
- Responsible for accurate assessments and documentation, reporting to appropriate personnel as indicated (i.e., on-call provider, operational manager, etc.)
- Assists provider during complex assessments, including observing Respite Aide and Providers with donning/doffing appropriate Personal Protective Equipment (PPE)
- Observe and report any adverse reactions.
- Responsible for updating and maintaining accurate treatment records, flow sheets, documenting appropriately
- Participate actively in New Patients Rounds, Team Rounds, and all other Team meetings when appropriate
- Responsible for giving and receiving report at change of shift; checking narcotics and related drug supplies per policy; sign appropriate forms.
- Responsible for taking off orders accurately, per policy.
- Responsible for assigning specific individual tasks to, and directing Respite Aides, and giving each a verbal report on patients' needs.
- Maintains a professional approach with confidentiality.
- Maintains the standards of accurate and complete recording and reporting.
- Ensuring that the clinical record for each patient on his/her Team is current and accurate.

Qualifications:

- Licensed as RN in the State of Connecticut
- 3 - 5 years of experience; new RNs will not be considered
- Experience with underserved population, behavioral health experience preferred
- Life support training certification (e.g. CPR, BLS, ACLS) from a course that includes a hands-on, in-person

component. If not certified prior to the start date, applicants must submit certification within 60 days of the start date.

- Naloxone trained preferred
- Strong medical assessment skills.

9 | Appendices:

Appendix A: Employee Tracking

[illegible]

Appendix B: PPE Protocols

Procedure for Donning PPE

1. Perform hand hygiene
 - a. Sanitizer, or
 - b. Wash with soap and water
2. Don first pair of gloves
 - a. Clean, nonsterile
 - b. Inspect for tears or holes
3. Don gown
 - a. Make sure you, or spotter, ties gown
 - b. Can be blue or yellow gowns
4. Don mask with connected face shield **or** mask, then face shield (if not connected)
5. Don second pair of gloves. Make sure they are pulled **over** sleeves of gown

Procedure for Doffing PPE

1. Doff outer gloves
 - a. Grasp **OUTSIDE** of the outer gloves with opposite hand, peel off and hold in double gloved hand. With single gloved hand, slide finger **UNDER** the outer glove of opposite hand at wrist and peel off. Discard.
2. Doff gown
 - a. Grab gown at shoulders and tear (or untie at neck) and peel away and down touching the inside only. Discard.
3. Doff inner gloves
 - a. Use same technique as above (#1).
4. Perform hand hygiene
 - a. Sanitizer, or
 - b. Wash with soap and water
5. Doff mask with face shield
 - a. With clean hands, remove mask by the straps behind ears, being careful not to touch the front of the mask. Discard.
6. Perform hand hygiene
 - a. Sanitizer, or
 - b. Wash with soap and water

Ref: Boston Health Care for the Homeless Program

Appendix C: CAGE & Modified Mini Questionnaire

First Name:	Last Name:
DOB:	Date of Exam:

CAGE

1a)	Have you ever felt you needed to cut down on your drinking?	Yes	No
1b)	Have you ever felt you needed to cut down on your drug use?	Yes	No
2a)	Have people annoyed you by criticizing your drinking?	Yes	No
2b)	Have people annoyed you by criticizing your drug use?	Yes	No
3a)	Have you felt guilty about drinking?	Yes	No
3b)	Have you felt guilty about drug use?	Yes	No
4a)	Have you ever needed a drink first thing in the morning to steady your nerves or to get rid of a hangover?	Yes	No
4b)	Have you ever felt you needed to use drugs first thing in the morning to steady your nerves or to avoid withdrawals?	Yes	No

MODIFIED MINI

1)	Have you been consistently depressed or down, most of the day, nearly every day, for the past two weeks?	Yes	No
2)	In the past two weeks, have you been less interested in most things or less able to enjoy the things you used to enjoy most of the time?	Yes	No
3)	Have you felt sad, low or depressed most of the time for the last two years?	Yes	No

4)	In the past month did you think that you would be better off dead or wish you were dead?	Yes	No
5)	Have you ever had a period of time when you were feeling ‘up’, hyper or so full of energy or full of yourself that you got into trouble, or that other people thought you were not your usual self? (Do not consider time when you were intoxicated on drugs or alcohol).	Yes	No
6)	Have you ever been so irritable, grouchy or annoyed for several days, that you had arguments, verbal or physical fights, or shouted at people outside your family? Have you or others noticed that you have been more irritable or overreacted, compared to other people, even when you thought you were right to act this way?	Yes	No
7)	Have you had one or more occasions when you felt intensely anxious, frightened, uncomfortable or uneasy even when most people would not feel that way? Did these intense feelings get to be their worst within 10 minutes? (If “yes” to both questions, answer “yes”, otherwise check “no”)	Yes	No
8)	Do you feel anxious, frightened, uncomfortable or uneasy in situations where help might not be available or escape might be difficult?	Yes	No
9)	Have you worried excessively or been anxious about several things over the past 6 months? (If you answered “no” to this question, please skip to Question 11.)	Yes	No
10)	Are these worries present most days?	Yes	No
11)	In the past month, were you afraid or embarrassed when others were watching you or when you were the focus of attention? Were you afraid of being humiliated?	Yes	No
12)	In the past month, have you been bothered by thoughts, impulses, or images that you couldn’t get rid of that were unwanted, distasteful, inappropriate, intrusive or distressing?	Yes	No
13)	In the past month, did you do something repeatedly without being able to resist doing it?	Yes	No
14)	Have you ever experienced or witnessed or had to deal with an extremely traumatic event that included actual or threatened death or serious injury to you or someone else?	Yes	No

15)	Have you re-experienced the awful event in a distressing way in the past month?	Yes	No
16)	Have you ever believed that people were spying on you, or that someone was plotting against you, or trying to hurt you?	Yes	No
17)	Have you ever believed that someone was reading your mind or could hear your thoughts, or that you could actually read someone's mind or hear what another person was thinking?	Yes	No
18)	Have you ever believed that someone or some force outside of yourself put thoughts in your mind that were not your own, or made you act in a way that was not your usual self? Or have you ever felt that you were possessed?	Yes	No
19)	Have you ever believed that you were being sent special messages through the TV, radio, or newspaper? Did you believe that someone you did not personally know was particularly interested in you?	Yes	No
20)	Have your relatives or friends ever consider any of your beliefs strange or unusual?	Yes	No
21)	Have you ever heard things other people couldn't hear, such as voices?	Yes	No
22)	Have you ever had visions when you were awake or have you ever seen things other people couldn't see?	Yes	No
23)	Have you ever lost considerable sum of money through gambling or had problems at work, in school, with you family and friends as a result of your gambling?	Yes	No

Administrative/ Clinical Use: Please write down the total score of CAGE and Modified Mini Screening

CAGE Score _____ Modified Mini Score _____

Staff Signature _____ Date of Evaluation _____

Appendix D: AMA Protocol

Procedure for patients who wish to leave against medical advice

All patients on the COVID-19 ward will be asked to read and sign a letter from the City stating the importance of voluntary isolation as they recover from COVID-19. Admitting staff should sign the form as well.

Staff member working on COVID unit makes every effort to counsel patient on risks of leaving. This should include reminding the patient of the form they signed on admission about the need for voluntary isolation.

If patient still wishes to sign out Against Medical Advice, a staff member on the COVID unit will discuss options with patient and Administrative on call about offering other options for safe quarantine such as hotel options in the area. Security can be radioed and request an ambulance or other safe transport to assist a patient who is leaving against advice from an area of isolation with confirmed COVID-19. The team will also contact the Respite Medical Director and inform them that a patient is leaving an area of isolation with confirmed COVID-19.

COVID unit staff member calls Charge RN, and informs them that patient is leaving AMA. Charge RN/Nursing Supervisor calls Security, to inform them that a patient will be escorted out.

Security will don PPE and prepare to hold the elevator when patient and staff arrive to the front door.

COVID unit staff member places mask and gloves on patient and unzips unit passageway.

COVID unit staff should document the above in a progress note including efforts that were made to prevent the patient from leaving.

Procedure for transport

In the event that a patient needs to be transported off the unit, the patient should be given a mask and gloves.

If the patient is ambulatory, they should walk out of the ward accompanied by staff*. If a patient is being sent out to the hospital, wait inside the unit for EMS. They will come prepared with the proper PPE and procedure. They can take the patient on a stretcher with a mask and clean sheet over them.

If the patient needs a wheelchair they should be placed in the wheelchair and wheeled out of the ward.

Ref: Boston Health Care for the Homeless Program

Appendix E: Fire Drill Procedure

Procedure for Fire Drill

In the event of a Fire drill the following steps will be taken

1. Patients will shelter in place in their rooms
2. All staff working on the COVID ward at the time will return to the ward
3. Staff will take attendance of the patients and staff present on the ward and report this to the nursing supervisor at***.

In the event of a fire on the COVID-19 ward, the patients will be masked and gloved and escorted by nursing outside and congregate at the ***

Ref: Boston Health Care for the Homeless Program

Appendix F: Advanced Code Blue Protocol

Purpose:

To provide guidance and framework around how staff should respond to a code blue or emergency event in the COVID-19 ward.

Policy:

The goal of this policy is to provide safe and effective emergency care for patients on the COVID-19 ward while minimizing additional viral exposures to patients and staff.

Roles:

The following code team roles should be identified by members of the ward. If care cannot be safely provided given the number of staff members present please consider calling for extra help.

1. Patient care #1 (inserts airway, takes vital signs, administers any medications)
2. Runner (available to communicate with the rest of staff, pick up meds if needed)

The following are optional roles

Recorder/Leader: Thinks out loud about what is happening, makes management decisions, records what happened and when. Documents after the code (could be done by #1 above if needed)

Patient care #2: assists #1 in the clinical care of the patient

Procedure:

In the event of an emergency situation on the COVID-19 ward, the following steps should be taken

- 1) Assess the patient
- 2) Call for help – overhead page “CODE BLUE COVID-ward”
- 3) Only COVID team members should put on PPE and go to the CODE.
- 4) The nursing supervisor, or designee, will go to the end of the ward (patient side) and communicate verbally with the code team through the plastic wall.
- 5) Care for the patient as you would usually in an emergency with the following caveats
 - a) Should an oral airway be needed, two staff should be designated for direct patient care. These two staff members should take the following steps
 - i) Make sure code kit is open and N95 is within reach
 - ii) Take off outer glove
 - iii) Don N95 mask over the surgical mask
 - iv) Put on new pair of gloves
 - v) Place oral airway
 - b) In the event of a seizure and IV Ativan is needed
 - i) The team should communicate this request to the nursing supervisor
 - ii) The nursing supervisor or designee will bring the Ativan to the decontaminated side of the ward.
 - iii) The nursing supervisor or designee will don PPE in the SOUTH anteroom (administrative wing), enter COVID unit and hand Ativan to staff member.

- iv) The Nursing Supervisor or designee will doff PPE per protocol
 - 6) If needed, EMS Will enter the ward through the patient entrance.
- Ref: Boston Health Care for the Homeless Program*

Appendix G: Patient Orientation Checklist

- ☐ Patient has completed medical intake form with medical staff
- ☐ Patient has completed authorization for release of information form with administrative or medical staff
- ☐ Patient is aware of rights and responsibilities as a member of the facility
- ☐ Patient is aware of emergency procedures
 - ☐ Fire emergency procedures
 - ☐ Medical emergency procedures
 - ☐ Security emergency procedures
- ☐ Patient is aware of the daily schedule
- ☐ Patient is aware of sick call procedures
- ☐ Patient knows the physical layout of the facility
 - ☐ Off-limits areas
 - ☐ Living quarters and personal space
 - ☐ Male/female locker room, shower, and restroom
 - ☐ Dining area
 - ☐ Laundry area
 - ☐ Entertainment area

Appendix H: Discharge Flow Chart

Point of Contact: _____

New referrals to the COVID-19 respite will include patient's prior housing situation and contact info for the patient's case manager, if applicable. Upon admission, the social worker (Administrative Staff) will begin to work with the patient on discharge planning by following the discharge flowsheet. The COVID-19 respite will not have the capacity to link patients with permanent housing, but will link patients with existing or new case managers as needed.

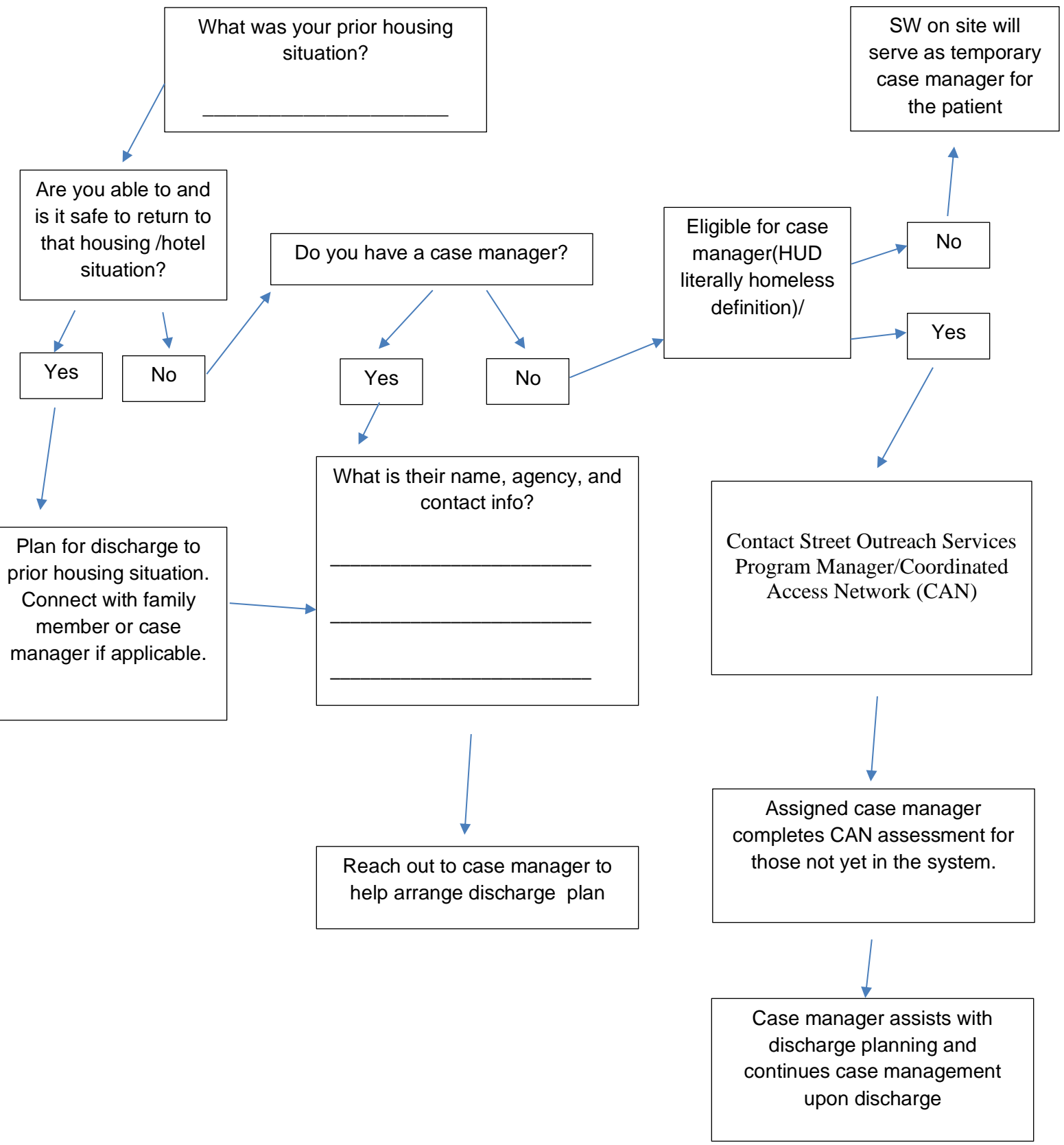
Options for discharge will include:

- 1) Return to prior housing situation when medically cleared (shelter/hotel, doubled-up)
- 2) Alternate housing e.g. through family/friends
- 3) Entry to shelter/hotel system by referral
- 4) Arrangement for permanent housing through case manager in the community
- 5) Discharge to street only if patient chooses and patient refuses other options

If client chooses to leave on their own when medically ready for discharge, medical transport can be provided to 3 distinct locations:

- i) New Haven Green
- ii) Fair Haven near McDonalds
- iii) Edgewood Park.

If client walks out of the facility, refusing transportation, when medically ready for discharge, there will be no further intervention on the part of Shelter One staff or NHPD. If not medically ready for discharge, refer to "AMA Protocol."



Appendix I: Respite Intake Form

COVID (+) Medical Respite Intake Revised on 4/7/20

Respite Program Name & Date: _____

Intake performed by Initials: _____

Applicant (Head of Household) Information:

First Name: _____ **Last Name:** _____

Middle Name: _____ **Suffix:** _____

Name Data Quality: ☐ Full Name Reported ☐ Partial, Street Name, or Code Name reported ☐ Client Doesn't Know ☐ Client Refused

Date of Birth: __/__/____ ☐ Approximate or Partial DOB Reported ☐ Client Doesn't Know ☐ Client Refused

Social Security Number: _____ - _____ - _____

☐ Approximate or Partial SSN Reported ☐ Client Doesn't Know ☐ Client Refused

Do you have a copy of your SSN card? ☐ Y ☐ N

Carry weapon? ☐ Y ☐ N

Photo ID? ☐ Y ☐ N

Driver's License? ☐ Y ☐ N

Birth Certificate? ☐ Y ☐ N

Gender: ☐ Male ☐ Female ☐ Transgender Male to Female

☐ Transgender Female to Male ☐ Other ☐ Client Doesn't Know ☐ Client Refused

If Other, please specify: _____

Primary Language: ☐ English ☐ Spanish ☐ French ☐ Portuguese ☐ Other

☐ Client Doesn't Know

If Other, please specify: _____

Relationship to HOH: ☐ Self ☐ Spouse ☐ Child ☐ Grandparent ☐ Guardian

☐ Other ☐ Client Doesn't Know

If Other, please specify: _____

Race: ☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Client Doesn't Know ☐ Client Refused

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Client Doesn't Know

☐ Client Refused

Citizenship Status: ☐ U.S. Citizen ☐ Non-Citizen ☐ Eligible Non-Citizen
☐ Ineligible Non-Citizen ☐ Undocumented ☐ Client Doesn't Know

Cell Phone: _____ Work Phone: _____
Email: _____

Emergency Contact Name and Phone #:

Veteran Status: Have you ever been on active duty in the U.S. Military? ☐ Yes ☐ No
☐ Client doesn't know ☐ Client refused

If "YES" to Veteran Status:

DD214 Order Date (optional) ____/____/____ **DD214 Receive Date (optional)** ____/____/____

Service Connected Disability? ☐ Yes ☐ No ☐ Don't Know ☐ Refused

Branch of military: ☐ Air Force ☐ Army ☐ Marines ☐ Navy ☐ Coast Guard

☐ Client Doesn't Know ☐ Client Refused ☐ Other

Date Entered Service ____/____/____

Reserves? (optional) ☐ Yes ☐ No

What was your discharge status: ☐ Honorable ☐ General under Honorable Conditions
☐ Under Other than Honorable Conditions ☐ Bad Conduct ☐ Dishonorable ☐ Uncharacterized
☐ Client Doesn't Know ☐ Client Refused

Years of Service: _____ **to** _____

Months of Active Duty: _____

Served in a war zone: ☐ Yes ☐ No ☐ Don't Know ☐ Refused

Theatre of Operations: ☐ World War II ☐ Korean War ☐ Vietnam War
☐ Persian Gulf War (Operation Desert Storm) ☐ Afghanistan (Operation Enduring Freedom) ☐ Iraq (Operation Iraqi Freedom) ☐ Iraq (Operation New Dawn)
☐ Other Peace-keeping Operations or Military Interventions

Client Served Location: _____

After reviewing the Diversion assessment information (if a Screen was conducted), discuss what led to their housing crisis and/or to seek shelter and what plans there are for future living arrangements.

If you don't come back, where would you most likely go? (Formerly "What are your plans for future living arrangements and leaving the shelter") **(describe): (Do not read responses. Ask question and then choose one.**

- | | |
|---|---|
| <input type="checkbox"/> Emergency Shelter or hotel / motel paid for with ES voucher | <input type="checkbox"/> Rental by yourself with VASH subsidy |
| <input type="checkbox"/> Foster care or foster care group Home | <input type="checkbox"/> Rental by yourself with GPD TID subsidy |
| <input type="checkbox"/> Hospital or other residential non-psychiatric medical facility | <input type="checkbox"/> Rental by yourself other ongoing housing subsidy |
| <input type="checkbox"/> Hotel / Motel paid without ES voucher | <input type="checkbox"/> Residential project or halfway house with no homeless criteria |
| <input type="checkbox"/> Jail, prison, or juvenile detention facility | <input type="checkbox"/> Safe Haven |
| <input type="checkbox"/> Long-term care facility or Nursing Home | <input type="checkbox"/> Staying or living with Family member, permanent tenure |
| <input type="checkbox"/> Moved from one HOPWA funded project to HOPWA PH | <input type="checkbox"/> Staying or living with Family member, temporary tenure |
| <input type="checkbox"/> Moved from one HOPWA funded project to HOPWA TH | <input type="checkbox"/> Staying or living with Friend, permanent tenure |
| <input type="checkbox"/> Owned by client, no housing subsidy | <input type="checkbox"/> Staying or living with Friend, temporary tenure |
| <input type="checkbox"/> Owned by client, with housing subsidy | <input type="checkbox"/> Substance Abuse treatment facility or detox center |
| <input type="checkbox"/> Permanent housing for formerly homeless persons | <input type="checkbox"/> Transitional housing for homeless persons |
| | <input type="checkbox"/> Client doesn't know |
| <input type="checkbox"/> Place not meant for human habitation | <input type="checkbox"/> Client refused |
| <input type="checkbox"/> Psychiatric Hospital or other psychiatric facility | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Rental by client, no housing subsidy | _____ |

Living Situation:

Type of Residence: **(Do not read responses. Ask question and then choose one.)**

- | | |
|--|--|
| <input type="checkbox"/> Emergency Shelter or hotel / motel paid with ES voucher | <input type="checkbox"/> Rental by client, with VASH subsidy |
| <input type="checkbox"/> Foster care or foster care group Home | <input type="checkbox"/> Rental by client, with GPD TID subsidy |
| <input type="checkbox"/> Hospital or other residential non-psychiatric medical facility | <input type="checkbox"/> Rental by client, other ongoing housing subsidy |
| <input type="checkbox"/> Hotel / Motel paid without ES voucher | <input type="checkbox"/> Residential project or halfway house with no homeless criteria |
| <input type="checkbox"/> Interim Housing | <input type="checkbox"/> Safe Haven |
| <input type="checkbox"/> Jail, prison, or juvenile detention facility | <input type="checkbox"/> Staying or living in a family member's room, apartment or house |
| <input type="checkbox"/> Long-term care facility or Nursing Home | <input type="checkbox"/> Staying or living in a friend's room, apartment or house |
| <input type="checkbox"/> Owned by client, no housing subsidy | <input type="checkbox"/> Substance Abuse treatment facility or detox center |
| <input type="checkbox"/> Owned by client, with ongoing housing subsidy | <input type="checkbox"/> Transitional housing for homeless persons |
| <input type="checkbox"/> Permanent housing for formerly homeless persons (CoC Project, HUD Legacy Program, HOPWA PH) | <input type="checkbox"/> Client doesn't know |
| <input type="checkbox"/> Place not meant for human habitation | <input type="checkbox"/> Client refused |
| <input type="checkbox"/> Psychiatric Hospital or other psychiatric facility | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Rental by client, no ongoing housing subsidy | _____ |

Length of Stay in the Prior Living Situation?

- | | | |
|--|---|--|
| <input type="checkbox"/> One night or less | <input type="checkbox"/> One month or more, but less than 90 days | <input type="checkbox"/> One year or longer |
| <input type="checkbox"/> Two days to six nights | <input type="checkbox"/> 90 days or more, but less than one year | <input type="checkbox"/> Client doesn't know |
| <input type="checkbox"/> One week or more, but less than one month | | <input type="checkbox"/> Client refused |

Approximate Date Homelessness Started ____/____/____

Last/Current Street

Address _____ **Unit:** _____ **City:** _____ **State:** _____

ZIP: _____

Regardless of where they stayed last night—Number of Times the Client Has Been Homeless on the Streets, in ES, or SH in the Past Three Years Including Today:

- | | | |
|---|--|---|
| <input type="checkbox"/> Never in 3 Years | <input type="checkbox"/> Three Times | <input type="checkbox"/> Client refused |
| <input type="checkbox"/> One Time | <input type="checkbox"/> Four or More Times | |
| <input type="checkbox"/> Two Times | <input type="checkbox"/> Client doesn't know | |

Total Number of Months Homeless on the Streets, in ES, or SH in the Past Three Years:

- | | |
|---|--|
| <input type="checkbox"/> One Month (this time is the first time) | <input type="checkbox"/> More than 12 months |
| <input type="checkbox"/> 2-12 Months (Specify # of Months: _____) | <input type="checkbox"/> Client Doesn't Know |
| | <input type="checkbox"/> Client Refused |

Domestic Violence Survivor? (*Head of Household and All Adults*):

- ☐ Yes ☐ No ☐ Don't Know ☐ Refused

If "YES:" When experience occurred?

- | | | |
|---|--|---|
| <input type="checkbox"/> Within the past three months | <input type="checkbox"/> Six months to one year ago (excluding one year exactly) | <input type="checkbox"/> Client refused |
| <input type="checkbox"/> Three to six months ago (excluding six months exactly) | <input type="checkbox"/> One year ago or more | |
| | <input type="checkbox"/> Client doesn't know | |

If "YES:" Are you currently fleeing? ☐ Yes ☐ No ☐ Don't Know ☐ Refused

Non-cash benefit from any source? (All Clients) ☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused ☐ Data Not Collected

Non-cash benefits received by or on behalf of a minor child should be recorded as part of the household income under the Head of Household.

	Head of Household	HH Member 1	HH Member 2	HH Member 3	HH Member 4
	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO
(SNAP) Food Stamps					
Special Supplemental Nutrition Program for WIC					
TANF Child Care Services					
TANF Transportation					
Other TANF Funded Services					
Section 8, Public Housing or Rental Assistance					
Temporary Rental Assistance					
Client Doesn't know					
Client Refused					
Other (Please Specify):					

Disabling Conditions (All Clients): ☐ Yes ☐ No ☐ Client Doesn't Know ☐ Client Refuse

	Head of Household	HH Member 1	HH Member 2	HH Member 3	HH Member 4
Physical Disability (All Clients) <i>Yes, No, Client Doesn't Know, Client Refused</i>					
If yes, Documentation of the disability and severity on file? <i>Yes, No</i>					
If yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently? <i>Yes, No, Client Doesn't Know, Client Refused</i>					
If yes, Currently receiving services/treatment for this disability? <i>Yes, No, Client Doesn't Know, Client Refused</i>					

Developmental Disability (All Clients) <i>Yes, No, Client Doesn't Know, Client Refused</i>					
If yes, Expected to substantially impair ability to live independently? <i>Yes, No, Client Doesn't Know, Client Refused</i>					
If yes, Documentation of the disability and severity on file? <i>Yes, No</i>					
If yes, Currently receiving services/treatment for this disability? <i>Yes, No, Client Doesn't Know, Client Refused</i>					
Chronic Health Condition (All Clients) <i>Yes, No, Client Doesn't Know, Client Refused</i>					
If yes, expected to be of long-continued and indefinite duration and substantially impairs ability to live independently? <i>Yes, No, DK, Refused</i>					
If yes, Documentation of the disability and severity on file? <i>Yes, No</i>					
If yes, Currently receiving services/treatment for this condition? <i>Yes, No, Client Doesn't Know, Client Refused</i>					
HIV/AIDS (All Clients) <i>Yes, No, Client Doesn't Know, Client Refused</i>					
If yes, Expected to substantially impair ability to live independently? <i>Yes, No, Client Doesn't Know, Client Refused</i>					

If yes, Documentation of the disability and severity on file? <i>Yes, No</i>					
If yes, Currently receiving services/treatment for this condition? <i>Yes, No, Client Doesn't Know, Client Refused</i>					
Mental Health Problem (All Clients) <i>Yes, No, Client Doesn't Know, Client Refused</i>					
If yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently? <i>Yes, No, Client Doesn't Know, Client Refused</i>					
If yes, Documentation of the disability and severity on file? <i>Yes, No</i>					
If yes, Currently receiving services/treatment for this condition? <i>Yes, No, Client Doesn't Know, Client Refused</i>					
Substance Abuse (All Clients) <i>No, Alcohol Abuse, Drug Abuse, Both Alcohol and Drug, Client Doesn't Know, Client Refused</i>					
If yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently? <i>Yes, No, Client Doesn't Know, Client Refused</i>					
If yes, Documentation of the disability and severity on file? <i>Yes, No</i>					

<p>If yes, Currently receiving services/treatment for this condition? <i>Yes, No, Client Doesn't Know, Client Refused</i></p>					
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Does the client need assistive technology? ☐ Yes ☐ No

If "yes" specify:

Other contributing factors, ask each question individually:

Criminal Justice Involvement: ☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused

Legal Eviction or Foreclosure: ☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused

Expense Exceed Income: ☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused

Was doubled up, could no longer stay with friend/family: ☐ Yes ☐ No

☐ Client doesn't know ☐ Client refused

What is the PRIMARY reason you are experiencing homelessness? *(Do not read responses. Ask questions and then choose one.)*

☐ Criminal Justice

☐ Involvement

☐ Domestic Violence

☐ Victim/Survivor

☐ Legal Eviction

☐ Exceed Income

☐ Substance Abuse Problem

☐ Employment

☐ Chronic Illness

☐ Developmentally Disabled

☐ Doubled Up

☐ HIV/AIDS

☐ Mental Health Problems

☐ Physical Health Affects

☐ Income and/or Hours

Income received from any source? ☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused

Income Type	Monthly Amount	Income Type	Monthly Amount
Unemployment Insurance		VA Non-Service-Connected Disability Pension	
Earned/Employed Income		Pension or Retirement income for another job	
Supplemental Security Income (SSI)		Child Support	
Social Security Disability Income (SSDI)		Alimony or other spousal support	
VA Service-Connected Disability Compensation		Worker's Compensation	
Private Disability Insurance		Other Source	
Retirement Income From Social Security			
General Assistance (GA)			
TANF		Client Income Total:	

Health Insurance: ☐ Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused

Type of Insurance	YES / NO	IF NO (*Note: This is NOT Required except for HOPWA Programs)
Medicaid / HUSKY A, C, D		<input type="checkbox"/> applied; decision pending <input type="checkbox"/> applied; client not eligible <input type="checkbox"/> did not apply <input type="checkbox"/> insurance type N/A <input type="checkbox"/> client doesn't know <input type="checkbox"/> client refused
Medicare		<input type="checkbox"/> applied; decision pending <input type="checkbox"/> applied; client not eligible <input type="checkbox"/> did not apply <input type="checkbox"/> insurance type N/A <input type="checkbox"/> client doesn't know <input type="checkbox"/> client refused
HUSKY B – Children's Health Insurance Program		<input type="checkbox"/> applied; decision pending <input type="checkbox"/> applied; client not eligible <input type="checkbox"/> did not apply <input type="checkbox"/> insurance type N/A <input type="checkbox"/> client doesn't know <input type="checkbox"/> client refused
Veterans Administration (VA) Medical Services		<input type="checkbox"/> applied; decision pending <input type="checkbox"/> applied; client not eligible <input type="checkbox"/> did not apply <input type="checkbox"/> insurance type N/A <input type="checkbox"/> client doesn't know <input type="checkbox"/> client refused
Employer-Provided Health Insurance		<input type="checkbox"/> applied; decision pending <input type="checkbox"/> applied; client not eligible <input type="checkbox"/> did not apply <input type="checkbox"/> insurance type N/A

		<input type="checkbox"/> client doesn't know <input type="checkbox"/> client refused
Health Insurance Obtained through COBRA		<input type="checkbox"/> applied; decision pending <input type="checkbox"/> applied; client not eligible <input type="checkbox"/> did not apply <input type="checkbox"/> insurance type N/A <input type="checkbox"/> client doesn't know <input type="checkbox"/> client refused
Private Pay Health Insurance		<input type="checkbox"/> applied; decision pending <input type="checkbox"/> applied; client not eligible <input type="checkbox"/> did not apply <input type="checkbox"/> insurance type N/A <input type="checkbox"/> client doesn't know <input type="checkbox"/> client refused
Indian Health Services Program		<input type="checkbox"/> applied; decision pending <input type="checkbox"/> applied; client not eligible <input type="checkbox"/> did not apply <input type="checkbox"/> insurance type N/A <input type="checkbox"/> client doesn't know <input type="checkbox"/> client refused
Other (specify)		<input type="checkbox"/> applied; decision pending <input type="checkbox"/> applied; client not eligible <input type="checkbox"/> did not apply <input type="checkbox"/> insurance type N/A <input type="checkbox"/> client doesn't know <input type="checkbox"/> client refused

What is your primary medical source? ☐ No health insurance ☐ No
☐ Client Doesn't Know ☐ Client Refused ☐ Yes ☐ No ☐ Client Doesn't Know

Insurance Policy Number : _____ (required if insurance type is Medicaid)

Insurance Policy Start Date: _____ (required if insurance type is Medicaid)

Insurance Policy End Date: _____

Pregnancy Status: ☐ Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused

☐ Data Not Collected

If "Yes:" Due Date? ____/____/____

Primary Language Spoken: ☐ English ☐ Spanish ☐ Chinese ☐ Russian ☐ Arabic
☐ Portuguese ☐ Bengali ☐ French ☐ Malay, Indonesian ☐ German ☐ Japanese
☐ Farsi (Persian) ☐ Urdu ☐ Punjabi ☐ Vietnamese ☐ Tamil ☐ Javanese ☐ Korean
☐ Turkish ☐ Telugu ☐ Marathi ☐ Italian ☐ Thai ☐ Burmese ☐ Kannada ☐ Gujarati ☐ Polish
☐ Hindi ☐ Cantonese ☐ Haitian Creole ☐ Unknown
☐ Other: _____

Religion: ☐ Protestant ☐ Catholic ☐ Jewish ☐ Muslim ☐ Buddhist ☐ Mormon
☐ Orthodox Christian ☐ Hindu ☐ Pentecostal ☐ None ☐ Other ☐ Unknown

Marital Status: ☐ Never married ☐ Married ☐ Separated ☐ Divorced/Annulled
☐ Widowed ☐ Civil Union ☐ Other ☐ Unknown

How were you referred to this facility? ☐ Self ☐ Family/Friend
☐ Mental Health Provider ☐ Substance Abuse Provider ☐ School ☐ Employer ☐ Church
☐ DSS ☐ Other community referral ☐ Police ☐ Shelter ☐ DOC ☐ Other ☐ Unknown

Do you Smoke? ☐ Yes ☐ No ☐ Unknown

Are you currently Employed? ☐ Employed full time ☐ Employed part time ☐ Unemployed ☐ Paid but non-competitive work ☐ SSI/SSDI ☐ Not in Labor Force ☐ Other ☐ Unknown

Highest level of education you completed? _____

How many adults are legally dependent on your income?

How many minors are legally dependent on your income?

Principal Source of Income: ☐ None ☐ Public Assistance ☐ Retirement ☐ Salary
☐ Disability ☐ Other ☐ Unknown

How many days have you lived in prison, hospital, group home or halfway house in the last 30 days?

How many times have you been arrested in the last 30 days?

How many times have you attended self-help programs/meetings attended in the last 30 days?

Have you interacted with family/friends in the last 30 days? ☐ Yes ☐ No

The listing of clinical disorders (Axis 1 Diagnosis-use ICD10
codes): _____ GAF Score (1-
100): _____

Type of drug currently using: ☐ None ☐ Amphetamines ☐ Alcohol ☐ Barbiturates
☐ Benzodiazepines ☐ Cocaine ☐ Crack ☐ Hallucinogens: LSD, DMS, STP etc. ☐ Heroin
☐ Inhalants ☐ Marijuana ☐ Methamphetamines ☐ Non-prescriptive methadone
☐ Over the counter ☐ PCP ☐ Tranquilizers ☐ Other ☐ Unknown

Drug delivery method used: ☐ Oral ☐ Smoking ☐ Inhalation ☐ Injection ☐ Other ☐ Unknown

How many times have you used the drug in the last 30 days? _____

At what age you started using this drug? _____

Additional notes:

Immediate Needs

Are there any restrictions on where you (and your family) can live?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Describe:		
Do you have any preferences for a town or region of the state?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Describe:		
Any urgent or emergency needs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Describe:		
Any special needs, disabilities, or medical conditions?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, list:	Household Member Name	Special Needs/Disabilities/Conditions
Anyone on medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, list:	Household Member Name	Medications
Anyone have a physical problem that limits mobility or ability to self-care?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

If yes, list	Household Member Name	Mobility/Self-Care Issue	
Does anyone have an active order of protection against an abuser/batterer?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, identify	Name of Filer	Name of Respondent	
Does HH Head have government issued ID?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Do any household members lack government issued ID?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, names and ages	Household member without ID	Age	
Does anyone in the household have a case manager or worker at any social services agency?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, worker name and contact number	HH Member Name	Worker Name	Contact Number
Does the client have Advance Directive?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
If "yes" please provide the copy of Advance Directive document.			

Appendix J: Greater New Haven Coordinated Access Information Network Authorization for Release of Information

This authorization is voluntary. The information you authorize us to disclose may be subject to re-disclosure by the recipient and if the person or organization authorized to receive the information is not a health plan or health care provider, the information may no longer be protected by Federal privacy regulations. We may not condition your receipt of treatment, payment, enrollment, or eligibility for benefits on completion of this authorization.

NAME (LAST, FIRST): _____ **DATE OF BIRTH:** _____

I hereby authorize the agencies listed below to exchange the indicated information for the purpose of ensuring effective coordination of services. Initial each type of information to release:

_____ Medical/Mental Health	_____ Alcohol/substance treatment
_____ Education/Employment	_____ HIV/AIDS
_____ Criminal/Legal	_____ Other (indicate here): _____
_____ Housing	_____ All of the above

Agencies covered by the terms and conditions of this authorization are:

<input type="checkbox"/> AIDS Project New Haven <input type="checkbox"/> Amtrak Police <input type="checkbox"/> Beacon Health Options <input type="checkbox"/> Beth-El Center <input type="checkbox"/> BHCare <input type="checkbox"/> Branford Counseling Center <input type="checkbox"/> Bridges Healthcare <input type="checkbox"/> Career Resources/STRIVE <input type="checkbox"/> Christian Community Action <input type="checkbox"/> City of New Haven <input type="checkbox"/> Columbus House <input type="checkbox"/> Community Action Agency of New Haven <input type="checkbox"/> Community Dining Room <input type="checkbox"/> Community Solutions <input type="checkbox"/> Connecticut Court Support Services Division <input type="checkbox"/> Connecticut Department of Children and Families <input type="checkbox"/> Connecticut Department of Corrections <input type="checkbox"/> Connecticut Department of Housing <input type="checkbox"/> Connecticut Health Network <input type="checkbox"/> Connecticut Mental Health Center <input type="checkbox"/> Conn. St. Dept. of Mental Health & Addiction Services <input type="checkbox"/> Continuum of Care <input type="checkbox"/> Continuum Home Health <input type="checkbox"/> Cornell Scott Hill Health Center <input type="checkbox"/> Connecticut Coalition to End Homelessness <input type="checkbox"/> Downtown Evening Soup Kitchen <input type="checkbox"/> Loaves and Fishes <input type="checkbox"/> Jewish Family Services/CARE	<input type="checkbox"/> Easter Seals Goodwill <input type="checkbox"/> Emergency Shelter Management Services <input type="checkbox"/> Fellowship Place <input type="checkbox"/> Integrated Wellness Group <input type="checkbox"/> Jewish Family Services <input type="checkbox"/> Junta FOR Progressive Action <input type="checkbox"/> Leeway New Haven <input type="checkbox"/> Legal Assistance Association <input type="checkbox"/> Liberty Community Services <input type="checkbox"/> Marrakech, Inc <input type="checkbox"/> New Reach <input type="checkbox"/> RM4 Drop In Center <input type="checkbox"/> Spooner House/ACT, Inc <input type="checkbox"/> TEAM, Inc <input type="checkbox"/> The Connection, Inc. <input type="checkbox"/> United Way of Greater New Haven <input type="checkbox"/> United Way of Milford <input type="checkbox"/> Valley YMCA <input type="checkbox"/> Veterans Service Administration <input type="checkbox"/> VNA South Central Connecticut <input type="checkbox"/> Women and Family Life Center <input type="checkbox"/> Workforce Alliance/American Job Center <input type="checkbox"/> Yale School of Medicine <input type="checkbox"/> Yale-New Haven Hospital <input type="checkbox"/> Youth Continuum _____: Other
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I understand that some or all of my information may be protected under Federal regulations (42 C.F.R. Part 2) and/or Connecticut state law and cannot be further disclosed without my written consent. I further understand that this authorization will expire two years from the date I sign the authorization. I may revoke this authorization in writing at any time; however, any revocation will not be retroactive for information disclosures that have already occurred.

Client Signature: _____

Date: _____

Printed Name: _____

Note: If you are a legal guardian or representative, you must attach a copy of your legal authorization to represent the member and complete the following:

Signature of Guardian/Representative: _____

Date: _____

Print: _____

Legal Authority: _____

NOTICE TO RECIPIENT OF INFORMATION

All or a portion of this information may have been disclosed to you from records protected by Federal and/or Connecticut state law which prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law(s). A general authorization for the release of medical or other information is NOT sufficient for this purpose. In addition, Federal rules (42 C.F.R. Part 2) restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.