The Salvation Army of Dane County
Medical Shelter
REFERRAL

The Salvation Army of Dane County Medical Shelter Referral Protocol

What is Medical Shelter?

The Salvation Army of Dane County's temporary (i.e. 2-7 nights) Medical Shelter is reserved for individuals and/or families experiencing homelessness who have certain specific acute and/or contagious medical conditions which compromise their ability to safely and healthfully reside in a traditional nighttime-only shelter setting. Medical Shelter is not a solution or intended for people with chronic conditions. Individuals/families must be referred to Medical Shelter by Public Health or their healthcare provider. Individuals/families may collaborate with a Salvation Army case manager upon participation in Medical Shelter.

Examples of situations in which Medical Shelter may be appropriate:

Infectious illness that would be contagious to others in shelter
Illnesses or injuries requiring the use of a tub or extended bed rest
Post-operative recovery

To refer a patient to Medical Shelter, please fax or email the forms below:

Completed Medical Shelter Referral (Sections A, B and C)
Copy of the patient's discharge paperwork

Medical Shelter contact during the hours of 8am-4pm Monday through Friday:
(Please note: Medical Shelter referrals are taken Monday-Friday only. Please plan accordingly for future discharge)

Brehan Gevelinger
Phone: 608.250.2221
Fax: 608.256.0569
Brehan.Gevelinger@usc.salvationarmy.org

Please note the completion of the referral forms does not guarantee an offer of shelter. Placement is subject to availability of funds and screening for program eligibility.

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SECTION A

AUTHORIZATION FOR RELEASE OF INFORMATION

Note: All matters relating to client records are considered privileged and confidential and are treated as such by the employees of The Salvation Army. Information regarding such matters cannot be given without client consent.

_____ is herby granted my permission to
(Name of Agency, Program or Individual)

Release to | Obtain from _____
(circle one or both)

_____

_____
(Name and address of agency, program or individual)

Such information as may be necessary regarding _____
(Print full name of client)

Purpose of need for disclosure: _____

_____

_____

_____

This consent to disclose may be revoked by me at any time except to the extent that action has been taken in reliance thereon.

This consent (unless expressly revoked earlier) expires upon: _____
(specify date, event or condition upon which it will expire; not to exceed 90 days from date of signature below)

_____ _____
Signature of client or person authorized to consent Date

_____ _____
Witness Relationship to client

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SECTION B
(To be completed by treating clinician or medical provider)

Patient's Name_____ Date of Birth_____/_____/_____

1. Please indicate below the nature of the patient's current illness/condition:

2. Describe the patient's ability to ambulate?

   _____non-ambulatory/severely restricted _____no restrictions

   If ambulation is restricted, until what date is above restriction expected to last? _____

3. Does patient require complete isolation due to a communicable disease or contagious illness? YES | NO

   If yes, please specify condition in #1 above. Needs isolation until _____/_____/_____

4. Please indicate any special needs or instructions for patient:

5. Other comments:

Hospital/Clinic Name _____ Phone _____

Physician Name (PRINT) _____

Physician Signature _____ Date _____/_____/_____

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SECTION C
(To be completed by referring party)

1. If patient is hospitalized, when was he/she admitted? _____ Discharged? _____
   (date) (date)

2. Is the patient homeless (currently or prior to hospitalization)? Where is (or was, if hospitalized) the patient residing?

3. List source(s) and amount(s) of all income:

   Date(s) and amount(s) of income received in the past 30 days:

   Date(s) and amount(s) of next available income:

4. Please indicate arrangements for the following:

   Case Management:

   Food / Meals:

   Transportation:

_____ _____
Name of referring party (print) Agency/Hospital/Clinic affiliation

_____ _____ _____
Referring party's signature Phone Date