Crisis Residence
Provider Referral Form

Overview

The Community Access Crisis Residence supports people aged 21 and over who are experiencing a mental health crisis by providing a voluntary stay in a comfortable and supportive home-like setting. We offer an alternative to emergency room and inpatient care. Guests stay at the Crisis Residence by personal choice and can come and go at their leisure without a curfew. Our Crisis Residence aims to facilitate wellness by delivering trauma-informed, recovery-focused, and person-centered services that address the whole person as they work to stabilize their crisis and manage their mental health symptoms so that they can return to living in the community. The primary approach to our provision of services is through peer support. We offer 24/7 support by trained Peer Specialists (individuals with lived experience of mental health conditions). Individuals referred to Crisis Residence may be enrolled the same day, pending bed availability and proper documentation. Guests may stay up to 28 days determined by personal need in consultation with Crisis Residence staff. We want to work with you and your chosen network of providers and supports so please complete consents for each individual you would like us to work with when you return this referral. Inability to pay for services does not affect eligibility.

Date of Referral: ___/___/___ **Name of Applicant:** _____

DOB: ___/___/___ **Applicant Phone #:** _____

Applicant email: _____

Psychiatric diagnosis

(primary) _____ ICD 10 code: _____
(secondary) _____ ICD 10 code: _____
(tertiary) _____ ICD 10 code: _____

Medical Diagnosis (if applicable)

(primary) _____ ICD 10 code: _____
(secondary) _____ ICD 10 code: _____
(tertiary) _____ ICD 10 code: _____

Please list the contact information for all of your providers and support people. Include your psychiatrist, therapist, care coordinator, medical doctor or any other relevant providers or supports. Please complete attached consent form for each person you would like to participate.

Name: _____ **role** _____ **phone:** _____ **email:** _____

Agency: _____ **or Relationship:** _____

Name: _____ **role** _____ **phone:** _____ **email:** _____

Agency: _____ **or Relationship:** _____

Name: _____ **role** _____ **phone:** _____ **email:** _____

Agency: _____ **or Relationship:** _____

Insurance Information ____ N/A (if not insured)

Medicaid#_____

Managed Care Organization (MCO): _____ MCO ID #: _____

Other insurance:

Name / type of Insurance Company: _____ ID #: _____

Inability to pay for services does not affect eligibility.

Please answer the following questions:

1. Please indicate your reasons for seeking a stay at the respite center:

2. Please indicate what you /hope to gain from your stay at the respite center.
   How can staff collaborate with you towards these goals? Please be as specific as possible.

3. What supports (friends, family, providers) would you like to include in your recovery planning while you are here?

4. Please provide the approximate length of stay by Respite services by need:

   __ 7 Days
   __14 Days
   __ 21 Days
   __ 28 Days

_____	_____	_____
Print Name of Applicant	**Signature of Applicant**	**Date**

The following eligibility and enrollment consideration questions must be answered by the referring provider:

The person being referred:

1. Is experiencing emotional/ mental health distress or crisis
   ☐Yes ☐No

2. Is a resident of New York City
   ☐Yes ☐No

3. Is 21 years or older
   ☐Yes ☐No

4. Is a voluntary enrollee (Individual must choose to participate in Crisis Residence services)
   ☐Yes ☐No

5. Is prescribed medication: ☐Yes ☐No

6. Is able to take medication (please circle one): independently with reminders under supervision
   (Please attach complete medication list, if applicable).

7. Has an agreed upon place to return to at the conclusion of the stay ☐Yes ☐No (NOTE: People who are street homeless or in a shelter may be accepted)
   Discharge address/ location:_____

8. Is in stable physical health which includes **not** needing inpatient detoxification services
   ☐Yes ☐No

9. (Please note, all bedrooms are on the 3rd and 4th floor) Is the person being referred able to navigate three flights of stairs ☐Yes ☐No

Please note that the Crisis Residence cannot enroll individuals that are at high risk of harm to self or others. We also cannot admit persons with a diagnosis of dementia, organic brain disorder or traumatic brain injury. Signing below affirms your knowledge that:

1. The person being referred is NOT at imminent risk of serious harm to self or others

2. The person being referred does NOT have a diagnosis of dementia, organic brain disorder or traumatic brain injury (TBI)

Referring Provider Name: _____

Referring Provider Agency Program Name: _____

Referring person contact information phone: _____ email: _____

Signature: _____ License #/Type: _____

Community Access Crisis Residence

Provider Referral Form: Medical Clearance

Related to COVID-19 Status

Please complete this form and send it back to us with the referral packet.

This form must be completed by a licensed medical professional.

A. Referrals from Article 28 clinic or Article 31 inpatient hospital setting

1. Attach a negative COVID-19 diagnostic PCR test from within 72 hours of referral.
2. If your client previously tested positive for the Covid-19 virus, please provide the following:
    a. A copy of test(s) results with date(s) of the last positive Covid-19 virus test and any subsequent negative tests.
    b. Documentation that shows that 14 days have passed since the first CLI symptom (or positive test result if the individual was asymptomatic), that the individual has been fever-free for at least 72 hours without the aid of fever reducing medications, and that the individual's respiratory symptoms have significantly improved.
3. Your signature below attests that your client has not had any new symptoms consistent with COVID-19 infections. and is cleared to be admitted to the respite center.

If your client previously tested positive for the Covid-19 virus, please provide the following:

- A copy of tests results with date(s) of the last positive COVID-19 virus test and any subsequent negative tests with the application
- Documentation that shows that 14 days have passed since the first CLI symptom (or positive test result if the individual was asymptomatic), that the individual has been fever-free for at least 72 hours without the aid of fever-reducing medications, and that the individual's respiratory symptoms have significantly improved.

B. **Referrals from community-based programs**:

Please ask and answer the following questions on behalf of your client:

1. Does your client report a sore throat? Y__ N__
2. Does your client report having a new cough? Y__ N__
3. Does your client report having a new condition of shortness of breath? Y__ N__
4. Does your client report loss of the sense of taste or smell? Y__ N__
5. In the past 14 days, has your client traveled to any country, state or city for which NYS requires that one quarantines for 14 days? Y__ N__
6. Record temperature here: ____

If you are able to obtain a COVID 19 test result that is 72 hours or less in age, please do so and attach the results here.

Your signature below attests that your client has not had any new symptoms consistent with COVID-19 infections and is cleared to be admitted to the respite center.

I attest that my client _____ is medically cleared to enter respite at this time.

_____ _____ ____ _____

Print Name Signature Date

License #: _____

Telephone #: _____

Email: _____

Guest Agreement

Welcome to the Crisis Residence!

The Crisis Residence is a place for you to work towards a resolution of your current mental health crisis. It is an opportunity to develop skills that can assist you in coping with future crises.

We follow current NYC DOHMH and Community Access COVID-19 policies and procedures. We expect your cooperation. This may include and is not limited to the following:

- *Daily temperature checks*
- *Frequent handwashing and hand sanitizer use, including at re-entry into the building.*
- *A mask must be worn at all times in the respite center when outside of your own room.*
- *Only essential providers may visit, such as ACT, PH and intensive mobile team staff, your Care Coordinator and OnTrack staff.*
- *Practice social distancing and maintain at least 6 ft. distance at all times.*
- *Observe posted room capacity limits throughout the building.*
- *In-person communication will take place in designated spaces, but may be ended if social distancing cannot be maintained.*
- *Minimize the number of times you go in and out of the building within a day.*
- *Use our reservation system to schedule dinner in the dining area, should you wish not to eat in your room.*
- *Sign up to reserve a time for the washer and dryer, available at no cost onsite.*
- *Use the wipes provided to clean and sanitize all bathroom surfaces after each use. Do NOT dispose of wipes into the toilet, but use the trash receptacle instead.*
- *Ensure frequent hand cleaning practices (sanitizer and washing, according to standards), especially when entering and exiting common and shared spaces.*

If at any time during your stay you develop COVID like symptoms, we will require that you restrict your movement between your bedroom and a designated bathroom. Staff will bring food to your door. Staff will facilitate your access to testing and reevaluate your stay with your input and that of your provider's.

Guest Agreement *(continued)*

In addition, we request that you abide by the following:

- *We encourage you to meet with us individually for peer support daily.*
- *It is expected that you sleep in the Respite each night as that is part of the basis of your admission.*
- *Sleeping in the common areas is not permitted.*
- *Entering another guest's room is not permitted.*

The Respite is smoke, alcohol and drug free. Please do not bring or use drugs or alcohol onsite. Cigarette smoking is permissible in our backyard only. If you do so, we ask that you use the ashtray provided.

We value everyone's safety and therefore violence is not tolerated and will result in immediate discharge. We do not permit weapons. Threats of violence, physical or sexual, can lead to discharge. We expect respectful communication, and ask that guests refrain from using language that is hateful and insulting.

Please manage your property at all times, and do not leave your property unattended. Community Access is not responsible for any lost or stolen items. When it is time for you to leave at the end of your stay at Respite, you must take all of your property with you when you go.

Your use of your medication is up to your own discretion. We expect you to store and take your medication independently.

On your last day, it is expected that you will leave the room as you found it. This includes washing your linens, remaking the bed, removing garbage and cleaning the room's surfaces, etc. It is expected that you will clean after yourself in the common areas during your entire stay.

Check out time is noon. To accomplish this we ask everyone to be up by 10:00 a.m.

The respite is always staffed. Should you have any questions we ask you to all at 646-257-5665.

We want your stay to be successful and so we strongly encourage you to follow the expectations set forth above. If you do not, it may result in your discharge.

I have reviewed all of the above and agree to these terms.

All participants will be offered a hard copy of this policy for their records.

Date: _____ Signature: _____