Forms for Transitioning Homeless Clients to Standard Care

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# Transition: Program Discharge Form

Client ID: Study ID:

Date of Client Discharge:

Staff Completing Discharge:

Type of Discharge (check all that apply):

* Completed Intervention (transitioned to SOC)
* Client Inactivity
* Client Moved
* Medical Complications
* Behavioral
* Limited Agency Capacity

Was a disruptive behavior contract enforced for this client? (Circle One) Y N

Final Assessment of Client:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe any additional information regarding client’s discharge:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Attached supporting documentation (where applicable):

* Behavioral Contract
* Correspondences
* Incident Reports
* Action Plans
* Other:

# Transition to Standard of Care Form

Client ID#\_\_\_\_\_\_\_\_\_\_\_\_

Check if Completed

\_\_\_\_\_ Client notes little/no need on client services plan

\_\_\_\_\_ Client is assigned stability level of self-management on acuity scale

Client has established and maintained self-sufficiency by SPNS & Positive Life standards and will be transitioned back to the standard of care. Client will still have access to services, as needed.

Date Transitioned:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Network Navigator Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Case Manager Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Program Manager Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# PATH Home Referral and Linkage

**PURPOSE:** To establish a process for identifying, referring and linkage multiply diagnosed HIV positive individuals to the PATH Medical Home Model.

**POLICY:** Through this 5 year SPNS/HRSA Demonstration Project, “Building a Medical Home for Multiply Diagnosed HIV+ Homeless Populations”, UF CARES in collaboration with River Region will develop a Medical Home Model for patients who are homeless or unstably housed.

Patients will be identified, referred and linked into comprehensive medical care and provided assistance with housing and other services through intensive case management and referral to an on-site clinic within a housing complex.

As part of the demonstration project, eligible patients may also participate in a multi-site evaluation study to evaluate models of care across nine other demonstration sites.

**PROCEDURE: Transitioning Out of PATH**

* + - Medical Case Manager and Comprehensive Case Manager will review the PATH Client Individualized Service Plan to ensure client is successfully working towards and achieving goals outlined in plan.
		- MCM & CCM will review the PATH Flow Check off sheet to ensure the client has been linked to all required services offered by the PATH program and the Client Transition Eligibility form is completed.
		- The treatment team, to include MSM, CCM, Peer Navigators, Medical provider and Mental Health provider, will meet to discuss successful transition out of the PATH Program.
		- Once treatment team agree on transition, the MCM and CCM will meet with client and his/her Primary Medical Case Manager (to be selected by client if not already selected) to discuss transition and client follow-ups in the PATH Program.
		- Documentation of decision to transition client is placed in CAREWare
		- The Ryan White/PAC Case Manger will began to take primary role with client and PATH MCM will serve as a support as needed.
		- The MCM will follow up with the client and Ryan White/PAC case manager to review client progress after being transitioned to Network Standard of Care for 3 months.
		- The Peer Specialists will continue to follow with patient as needed to provide support and assist with compliance
		- The Program Evaluator will continue to complete follow up interviews with client until 24 month program completion.

Congratulations! You have successfully completed the PATH program requirements. You are now on the PATH towards becoming self-sufficient, healthier living and are now more aware of the social and medical services available in Jacksonville, Florida.

Please keep the following information handy should a medical or social need arise. The list below is a primary resource to services you are connected to. Please be sure to check your RW and/or ADAP expiration dates often (**renewal is every 6 months**).

**Primary Care Provider**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Specialty Care Clinic/Provider**: \_\_\_UF CARES 904-XXX-XXXX\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Case Management Agency/Case Manager**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mental Health Services/Substance abuse:\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RW and/or ADAP**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Food Pantry**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dentist**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thank you for allowing the PATH team to assist you. It has been a privilege to get to know you and work alongside you. The PATH team wishes you much success and hope in the future.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient signature Date

# Transition Checklist

**Project mHEALTH**

**Yale University School of Medicine AIDS Program, Liberty Community Services,Connecticut Department of Correction**

See Transition Plan above. The transition checklist used by LCS is below:

Transition Checklist

To be completed 90 days after housing placement and every 30 days thereafter until person is transitioned to long term case management.

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Intake \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Housed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Completed by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_Person served has been housed at least 90 days.

Comments/Recommendations:

\_\_\_\_\_Person served has paid his/her portion of rent for 3 consecutive months.

Comments/Recommendations:

\_\_\_\_\_Person served demonstrates engagement with clinical care. This means generally keeps

medical/clinical appointments, generally adheres to medications and treatment plans, has some insight into recovery and is taking steps (at his/her own pace)

Comments/Recommendations:

\_\_\_\_\_Person served is managing budget (check all that apply)

\_\_\_\_\_Has money management or payee in place if necessary

\_\_\_\_\_Uses appropriate community resources for basic needs

\_\_\_\_\_Is not in crisis every month due to spending habits

Comments/Recommendations:

\_\_\_\_\_Person served is engaged in meaningful activity of some type (check all that apply)

\_\_\_\_\_Employment or employment program

\_\_\_\_\_Education or training

\_\_\_\_\_Spirituality

\_\_\_\_\_Fellowship meetings

\_\_\_\_\_Volunteerism

\_\_\_\_\_Reunited with family

\_\_\_\_\_Other

Comments/Recommendations:

Transition Plan:

Planned timeline: \_\_\_\_\_ Immediate \_\_\_\_\_ 30 Days \_\_\_\_\_60 Days \_\_\_\_\_\_90 Days

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Rationale: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Refer to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Organization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Services to be provided: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Follow Up Meeting/Contact Schedule (minimum 30, 60 and 90 days post transition):

Acknowledgments/Signatures:

Person Served: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Liberty Community Services: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Receiving Organization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_