Shelter Referral Form
for Persons Experiencing Homelessness

For questions please e-mail: COVID-19HomelessResponse@santacruzcounty.us
We will respond to referral requests in one business day

Date and Time of Referral: _____

Referred by: _____ _____ _____
Name **Organization/Shelter** **Phone Number**

Client Name: _____ **DOB:** _____ **Age:** _____

Spoken Language: _____ **Date of Symptom Onset (if applicable):** _____

Client's Priority Level (Please note, priority 4 persons are accepted *only* as space/need allows)**:**

☐ PRIORITY 1 - Persons experiencing homelessness that are **confirmed COVID-19 positive**

☐ PRIORITY 2 - Persons experiencing homelessness that are **presumed COVID-19 positive** (Client has COVID-19 symptoms **and** has been in known contact with COVID-19 positive individuals)

☐ PRIORITY 3 - Persons who public health would advise to self-quarantine because either of the following (check only one):
- ☐ Client has COVID-19 symptoms
- ☐ Client has had significant contact with COVID-19 positive individuals

☐ PRIORITY 4 - Persons experiencing homelessness that are **elderly (65+ years old) or medically vulnerable**. Explain client's medical vulnerability:
_____
_____

☐ PRIORITY 5 - All other homeless individuals that do not meet the criteria required for priorities 1-4.

Client Location - Where can client be found so that they can be transported to a Shelter in Place location? Please be as descriptive as possible, use back of form if additional space needed:

_____
_____
_____
_____
_____

Client Phone: _____ **Client Email:** _____

Someone that can relay message to client: _____ _____
Name **Phone**

For priority 4 clients, please list any people who the client could share a hotel room. Use back of form if additional space needed.

Name: _____Age: _____ Relationship:_____ Have/will have referral ☐

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Form Updated 4.16

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Medical Condition/Needs

Summary of medical condition and issues:

_____

_____

Physical Disabilities: _____ **Chronic Health Issues:** _____

Communication Issues (hearing, vision): _____ **TBI or Cognitive Issues:** _____

Does Client require ADA unit? ☐ Yes ☐ No **Does Client smoke?** ☐ Yes ☐ No

Known allergies (medication, food, other): _____

Assistive Devices: ☐ Yes: _____ ☐ No **Requires Insulin:** ☐ Yes ☐ No

Self Care: ☐ Yes ☐ No **Incontinent?** ☐ Yes ☐ No **Special Med. Requirements:**_____

Mental Health Diagnosis/Concerns: ☐ Yes: _____ ☐ No

Known Substance Abuse Issues: ☐ Yes: _____ ☐ No

Person Under Investigation? ☐ Yes ☐ No **Pet?** ☐ Yes ☐ No **If yes, type:** _____

Prefer North or South County? ☐ North ☐ South ☐ No preference

Care Team/Support

Primary Care Physician: _____ **Phone Number:** _____

Social Worker: _____ **Phone Number:** _____

Case Manager: _____ **Phone Number:** _____

Therapist/Psychiatrist: _____ **Phone Number:** _____

Treatment Program: _____ **Phone Number:** _____

Insurance (if known): _____

Additional Information – Use this space to write anything else pertinent to know for this referral:

_____

_____

_____

_____