DEPARTMENT OF HOMELESSNESS AND SUPPORTIVE HOUSING

Adult Coordinated Entry Administrative Review Form

San Francisco's Department of Homelessness and Supportive Housing (HSH) prioritizes clients for housing based on their barriers to housing, chronicity of homelessness, and vulnerability.

If your client has participated in Problem Solving and Coordinated Entry at an Adult Access Point and was not deemed high priority status for housing despite their high barriers to housing, high vulnerability, and high chronicity of homelessness, you may request a clinical review of your client's case by the Coordinated Entry Administrative Review Team. In order to request an administrative review, your client must first participate in the Coordinated Entry process at an Access Point.

Please fill out and submit this request for Coordinated Entry Administrative Review Form electronically. We use the information in this form and narrative information available in systems of record to evaluate the severity of your client's housing barriers, chronicity of homelessness, and vulnerability. **Please include as much detailed information as possible** in order to help the Coordinated Entry Administrative Review Team assess your client's situation. Some questions are of a sensitive nature.

Please complete all sections of this form. **Incomplete forms will not be accepted and will be returned to you for more information**. If you need to leave a section blank, please address the reason in the comments section.

The Administrative Review Team will notify you by email within 15 business days of your client's status. If your client is determined to be priority status by the Clinical Review Team, they will be added to the Coordinated Entry priority status list and referred to housing navigation services. If your client is not granted priority status, they may continue to participate in Problem Solving at an Adult Access Point.

Submitting the Request Form:

- Requests for Administrative Review must be saved in PDF format and emailed to HSHAdminReview@sfgov.org. **Please do not fill the form out by hand and scan or fax it.**
- Please adhere to best practices to keep your client's information safe:
    - Do not include identifying information in the email subject line or in the email body.
    - Send document via secure email. If you do not have access to secure email, the form must be password protected; passwords should be sent in a separate email.
    - Do not send referrals from a personal email account.

Client Identifying Information

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

AKAs

Last Name(s): _____ **First Name(s)**: _____

Nickname/Street Name(s): _____

SSN: _____ ☐ No SSN **DOB**: _____

Requesting Provider Information:

Name: _____

Title: _____

Agency: _____

Email: _____ Phone: _____

Date you began working with this client: _____

Is your client a US citizen?

☐ Yes ☐ No

Has your client served in the military?

☐ Yes ☐ No

Language:

☐ Speaks/reads English ☐ Monolingual, not English

* If Monolingual, not English, please select language(s) spoken:

☐ Spanish ☐ French ☐ Cantonese ☐ Korean ☐ Vietnamese ☐ Russian ☐ Other: _____

Ethnicity: (select one)

☐ Hispanic/Latino ☐ Other (Non-Hispanic/Latino) ☐ Don't Know ☐ Refused

Primary Race: (select one)

☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American

☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other ☐ Don't Know ☐ Refused

Secondary Race (Optional): (select one)

☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American

☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other ☐ Don't Know ☐ Refused

Which best describes your client's gender identification? (select one)

☐ Male ☐ Female ☐ M to F ☐ F to M ☐ Transgender ☐ Other: _____

What are your client's preferred pronouns?

☐ he, him, his ☐ she, her, hers ☐ they, them, theirs ☐ Other: _____

Client Income

Please report total monthly income client receives from all sources:

Total Monthly Income: $ _____

Income Source(s): (check all that apply)

☐ Social Security ☐ Supplemental Security Income ☐ CAAP ☐ CAPI ☐ CALM ☐ Employment

☐ Other (describe): _____

Physical Functioning and Locomotion

Please select your client's ability to perform the following tasks on their own:

Housework—How ordinary work around the house is performed (e.g. doing dishes, dusting, making beds, tidying up, laundry)

☐ Independent ☐ Some help ☐ Full help ☐ By others ☐ Activity did not occur

Shopping—How shopping is performed for food and household items (e.g. selecting items, managing money)

☐ Independent ☐ Some help ☐ Full help ☐ By others ☐ Activity did not occur

Does your client currently receive In Home Support Services? ☐ Yes ☐ No ☐ Will enroll

If yes, for how many hours are they eligible? _____

If no, have they been assessed? _____

Primary Modes of Locomotion

Indoors (select one)

☐ No Assistive Device ☐ Cane ☐ Walker/Crutch ☐ Manual Wheelchair ☐ Electric Wheelchair
☐ Activity did not occur (regardless of ability)

Outdoors (select one)

☐ No Assistive Device ☐ Cane ☐ Walker/Crutch ☐ Manual Wheelchair ☐ Electric Wheelchair
☐ Activity did not occur (regardless of ability)

Stair Climbing (select one)

In the last 3 days how client went up and down stairs (e.g. single or multiple steps, using handrail as needed)

☐ Up and down stairs without help ☐ Up and down stairs with help ☐ Unable to go up and down stairs

Do you anticipate your client will need an assistive device in the near future? ☐ Yes ☐ No

Has your client fallen in the past year? ☐ Yes ☐ No

If yes, approximately how many times?_____

Transportation — How client travels by vehicle (e.g. gets to places beyond walking distance)

☐ Independent ☐ Some help ☐ Full help ☐ By others ☐ Activity did not occur

Does your client currently use Paratransit? ☐ Yes ☐ No ☐ Will apply

Criminal Justice History

Please describe your client's criminal justice history to the best of your knowledge and ability (select all that apply)

☐ No criminal justice involvement

☐ History of arrests, *not* related to violence

If yes, please explain circumstances and give dates: _____

☐ History of arrests, related to violence

If yes, please explain circumstances and give dates: _____

☐ History of felony conviction

If yes, please explain circumstances and give dates: _____

☐ Registered Sex Offender (RSO)

If yes, please explain circumstances and give dates: _____

Housing History

Client's living situation <u>currently</u> (select one):

☐ Sleeping outside, encampment or vehicle Location(s): _____

☐ Couch surfing Location(s): _____

☐ Jail / Incarceration Name of facility: _____

☐ Board and Care Name of facility: _____

☐ Emergency / Domestic Violence Shelter Name of facility: _____

☐ Emergency Voucher / Stabilization Unit Location(s): _____

☐ Inpatient unit / ADU Name of facility: _____

☐ Skilled Nursing Facility Name of facility: _____

☐ Transitional Housing or treatment facility Name of facility: _____

Projected discharge date: _____

Client's living situation over the <u>past year</u> (check all that apply):

☐ Sleeping outside, encampment or vehicle Location(s): _____

☐ Couch surfing Location(s): _____

☐ Jail / Incarceration Name of facility: _____

☐ Board and Care Name of facility: _____

☐ Emergency / Domestic Violence Shelter Name of facility: _____

☐ Emergency Voucher / Stabilization Unit Location(s): _____

☐ Inpatient unit / ADU Name of facility: _____

☐ Skilled Nursing Facility Name of facility: _____

☐ Transitional Housing or treatment facility Name of facility: _____

☐ Other Please describe: _____

Which of the following best describes your client's homelessness situation:

☐ Homeless for less than 1 month ☐ Homeless between 1–12 months ☐ Homeless for more than 1 year

Has your client had 4 or more episodes of homelessness in the last 3 years?

☐ No ☐ Yes

If yes, do these episodes add to more than 12 months?

☐ No ☐ Yes

When did your client first become homeless? _____

What is the approximate lifetime length of homelessness your client has experienced? ____(years) ____(months)

Has your client ever maintained their own independent housing? If so, for how long, and how recently?

_____

Is your client experiencing physical or sexual violence in the place they are staying?

☐ No ☐ Yes

Has your client been victimized or targeted by others while living outside or in shelter?

☐ No ☐ Yes

Please enter a thorough narrative of your client's homeless history, including dates, locations, and as much detail as possible:

_____

Medical History and Medical Diagnoses (*Please add details at the end of the section)*

Does your client have a primary care provider with whom they are engaged?

☐ Yes Name of provider: _____ Clinic/hospital: _____

☐ No

If no, has client been referred to primary care provider?

☐ Yes Name of provider: _____ Clinic/hospital: _____

☐ No

Please check all chronic medical conditions your client has:

☐ Congestive Heart Failure
☐ Heart disease: _____
☐ History of stroke
☐ Peripheral edema
☐ Hypertension
☐ Paralysis
☐ Neurodegenerative disorders
☐ Cognitive decline
☐ Seizures
☐ Traumatic Brain Injury
☐ Diabetes ☐ Complicated ☐ Uncomplicated
☐ Chronic Pulmonary Disease
☐ Chronic Kidney Disease ☐ Requires dialysis
☐ Liver disease ☐ Cirrhosis
☐ Pressure/Decubitus ulcer ☐ Healed ☐ Unhealed
☐ HIV Viral Load: ☐ Detectable ☐ Undetectable
☐ Metastatic cancer
☐ Cancer without metastasis
☐ Gastrointestinal: _____
☐ Musculoskeletal: _____
☐ Dermatological: _____
☐ Obesity
☐ Weight loss
☐ Other: _____

Which of the following best describes your client's medical situation (check only one):

☐ No health complaints, client appears well
☐ Temporary medical problem (*e.g*. injection, wound, cast, splint)
☐ Chronic, but stable medical condition – Describe: _____
☐ Chronic, unstable medical condition – Describe: _____
☐ Untreated chronic or terminal condition that is *worsening* – Describe: _____

Does your client have symptoms with no explanation (Weight loss, swelling of limbs, open & untreated wound, recurrent chest pain, chronic cough, shortness of breath, unexplained cognitive impairment)?

☐ No
☐ Yes If yes, explain: _____

Does your client have an obvious *physical* problem that is not being cared for?

☐ No
☐ Yes If yes, explain: _____

Approximately how often has your client gone to the Emergency Department in the past 12 months (select one)?

☐ None in the past 12 months ☐ Less than 3 visits ☐ 3–5 visits
☐ 6–8 visits in the past 12 months ☐ 8 or more visits ☐ Unknown

Approximately how many times has your client been inpatient in an acute hospital in the past 12 months (select one)?

☐ None in the past 12 months
☐ 1 in-patient stay in the past 12 months
☐ 2–4 inpatient stays in the past 12 months
☐ 4 or more inpatient stays in the past 12 months
☐ Unknown

Approximately how many days total has your client been inpatient or in a skilled nursing facility in the past 12 months? _____

Client is able to manage prescribed medications and adhere to their use (including obtaining refills on time, taking medications as prescribed, maintaining compliance with prescribed medications):

☐ Not at all: Misses all doses without supervision, unable to obtain refills, does not take medications as prescribed
☐ Fairly well: Misses some doses without supervision, sometimes unable to obtain refills on their own
☐ Well: Takes most medications as directed, minimal prompting needed, makes good use of medi-sets
☐ Very well: Takes all medications as directed, no prompting or assistance needed, gets refills on time
☐ Exceptionally well: Never misses a dose of medications, highly responsible

Please describe your client's medical diagnoses, history, and condition as thoroughly as possible in your own words:

Mental Health History and Diagnoses (*Please add details at the end of the section)*

Does your client have a mental health provider with whom they are engaged?

☐ Yes Name of provider: _____ Clinic/hospital: _____
☐ No

If no, has client been referred to mental health provider?

☐ Yes Name of provider: _____ Clinic/hospital: _____
☐ No

Please check all mental health diagnoses your client has:

☐ Psychosis
☐ Schizophrenia
☐ Schizoaffective disorder
☐ Bipolar disorder Type: _____
☐ Major depression
☐ Post-traumatic stress disorder (PTSD)
☐ Anxiety
☐ Hoarding/Cluttering
☐ Personality disorder Specify traits: _____
☐ Other Specify: _____

Comments: _____

Which of the following best describes your client's mental health situation (select one):

☐ No mental health issues
☐ Reports feeling down about life circumstances or situation (no diagnosis)
☐ History of severe mental illness

If yes, ☐ Symptoms are being adequately treated

☐ Severe mental illness; symptoms presently impair functioning

If yes, ☐ In treatment ☐ Untreated

☐ Severe mental illness, or symptoms & behavior of mental illness; symptoms markedly impair functioning

If yes, ☐ In treatment ☐ Untreated ☐ Poor response to treatment

Mental Health symptoms are known to worsen with consumption of alcohol or substances:

☐ No ☐ Yes

Please describe any injectable medications your client takes and their adherence plan:

Please describe your client's mental health history, diagnoses, and condition as thoroughly as possible in your own words:

Alcohol and Substance Use History (*Please add details at the end of the section)*

Which substances does your client currently use?

☐ Alcohol (any use at all)
☐ Alcohol (to intoxication)
☐ Heroin
☐ Methadone
☐ Other Opiates/Analgesics
☐ Sedatives/Benzos/Tranquilizers
☐ Cocaine
☐ Amphetamines
☐ Cannabis
☐ Hallucinogens

Which substances does your client have a history using?

☐ Alcohol (any use at all)
☐ Alcohol (to intoxication)
☐ Heroin
☐ Methadone
☐ Other Opiates/Analgesics
☐ Sedatives/Benzos/Tranquilizers
☐ Cocaine
☐ Amphetamines
☐ Cannabis
☐ Hallucinogens

Which of the following best describes your client's current substance use patterns?

☐ None
☐ Not currently using, but high risk of relapse
☐ Strictly social use; no impact on functioning
☐ Sporadic used of substance; able to meet basic needs
☐ Use of substances affecting ability to meet basic needs; some trouble making progress in goals
☐ Use of substance impacting ability to gain/maintain functioning in many areas
☐ Active addiction markedly impacting functioning and meeting basic needs (food, housing, appointments)

Please describe your client's history of substance use as thoroughly as possible in your own words:

Functional Ability

Food, clothing, hygiene

☐ Generally able to use services to get food, clothing; take care of hygiene

☐ Some trouble staying on top of basic needs/hygiene but can usually care for self

☐ Able to get needs met with assistance

☐ Has not been able to get needs met, but no history of resisting offers of assistance in recent past

☐ Has not been able to get needs met, and has refused or resisted offers of help in recent past

Survival skills and safety (pedestrian safety, getting injured, networking and accessing social services)

☐ Strong survival skills; capable of networking and self-advocacy

☐ Medium survival skills; needs assistance recognizing unsafe behaviors

☐ Lacks street smarts; doesn't understand unsafe behaviors

☐ Poor survival skills; often in dangerous situations

☐ Clear disregard for personal safety

Attention, self-care, organizational skills

☐ Good attention span; adequate self-care; able to keep track of appointments

☐ Occasionally disorganized; may require minimal prompting

☐ Sometimes disorganized; occasional confusion with regard to orientation

☐ Disorganized or disoriented; Poor awareness of surroundings

☐ Highly confused; disorientation in reference to time, place and/or person

Communication, interpersonal skills

☐ Strong and organized communication; able to communicate clearly with case manager or provider

☐ Occasional trouble communicating needs

☐ Frequent difficulty in communicating

☐ Unable or unwilling to communicate effectively

☐ Significant inability communicating with others or refuses to talk with case manager

Coping skills, behavior, violence (select all that apply)

☐ Client has a history of physical violence

☐ Client has a history of verbal aggression

☐ Client is quick to anger and/or emotionally labile

Please describe: _____

Strengths and Challenges

Your client's strengths: _____

Activities your client enjoys: _____

Your client's primary challenges: _____

Other notes about your client that should be taken into consideration:

HSH Admin Use Only

ONE ID: _____

Primary Assessment Score: _____

Date reviewed: _____

Date notified provider of status: _____

Notes:

Score: _____

Nursing?	☐ Yes	☐ No		
Chronically homeless	☐ Yes	☐ No		
Utilization Summary:	Days inpatient ___	ED episodes ___	PES visits ___	SNF days ___