Recuperative Care Center (RCC) Referral Guidelines

What Is The Recuperative Care Center?

The Recuperative Care Center (RCC), is a 12 bed, 24 hour shelter, for homeless persons requiring medical respite. It is a joint effort through the Santa Cruz County Homeless Persons Health Project (HPHP), Housing Matters (HM), local hospitals and partners. Eligible patients receive medical care, meals, case management, support for mental health and substance use issues, transportation, and more.

Who Can Make A Referral?

Referrals are made by social workers, registered nurses and health care providers within Santa Cruz County. Patients may not refer themselves. Referrals should be placed through one of the Public Health Nurses at HPHP. Phone: (831) 454-2080, Fax (831) 454-3424.

When To Make A Referral

Referral requests are accepted and processed Monday through Thursday, 9am-4pm. Referrals should be made at least seven days in advance. A waiting list will be maintained on a first come, first served basis, if the Center is at maximum capacity; in some cases, based on need, the order of the list can be changed by HPHP.

What Happens Next?

The staff at HPHP will review the referral, and determine if the patient meets the eligibility criteria. Once the patient has been approved, they will be scheduled for intake, and provided with a physical assessment date. If the patient is not approved, i.e., requires a higher level of care, the referring party will be notified.

Requirements and Responsibilities

The resident must currently be homeless. Referral services to case managers and housing assistance will be available.

The resident must be self-sufficient in administering their medications. All medications must be taken as prescribed; abuse of painkillers, muscle relaxers, etc., is not allowed.

Must be independent in Activities of Daily Living (ADL’s).

12 step meetings, and other recovery programs are encouraged.
Each resident must have a 30 day supply of all their medications (unless a shorter course is prescribed), and any needed assistive devices, such as a Nebulizer, Wheelchair, O² tanks, C-PAP, Blood Glucose Monitor, etc.

Residents are expected to maintain physical cleanliness. Showers and bath tubs are available for daily use.

Residents must be willing to see a Public Health Nurse every day and comply with medical recommendations.

Residents should be bowel and bladder continent.

The resident must be medically and psychiatrically stable to receive care at the RCC, and may not currently be experiencing suicidal ideation, or intentions of violence towards others.

Each resident must have an identifiable end point of care for discharge.

Exceptions

The following criteria will exclude any applicants from participating in the RCC program:

- Megan's Law registrants
- Patients with unstable medical or psychiatric conditions that require an inpatient level of care
- Patients requiring IV medications or hydration
- Currently on Homeless Services Center banned client list

Contact Information

For questions regarding referrals, please contact:
Andi Wass, Public Health Nurse III at HPHP: Phone: (831) 454-5184, Fax: (831) 454-3424.

For questions regarding the patient once they are accepted, please contact:
RCC: Phone: (831) 440-7852, or (831) 458-6020, x1104.
Recuperative Care Center (RCC) Referral Form

Date and Time of Referral: ________________

Patient’s Name: _______________________________________________________

Patient Referred By: ________________________________________

Name ____________________________________________________________

Organization _______________________________________________________

Patient’s Date of Birth: ___________________________ SSN: ______________________

Insurance Provider: ___________________________ Number ______________________

Is Patient Homeless? Y N

Reason For Referral: ____________________________________________________________________________________

Surgery Performed At: ___________________________ Date of Surgery: ______________

Name of Surgeon: ___________________________ Phone Number: ______________________

Nature of Surgery: _______________________________________________________________________________________

When Bed Is Needed By: ___________________________ Expected Length of Stay: __________

Mental Health Diagnosis: ___________________________

In Santa Cruz County System of Care? Y N ID# ___________________________

Current Prescriptions: Medication/Dosage: (Patient must have at least 30 day supply of all medications and dressings upon arrival)

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________
Known Allergies (medication, food, other): ___________________________________________

Summary of Medical Condition and Issues (including PMH):
____________________________________________________________
____________________________________________________________
____________________________________________________________

Wound Care Instructions:
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Physical Disabilities: ________________________________________________________________

Chronic Health Issues: _______________________________________________________________


Self-Administer Meds? Y N Communicable Diseases? Y N

Incontinent? Y N Assistive Devices? Y N Requires Insulin? Y N

IV Antibiotics upon Discharge? Y N Requires Higher Level of Care? (Upon Discharge) Y N

Special Requirements: ____________________________________________________________
(diet, infectious disease concerns, etc.)

<table>
<thead>
<tr>
<th>Substance Abuse Issues:</th>
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<tbody>
<tr>
<td>Alcohol: Y N Last Used:</td>
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<tr>
<td>Drugs: Y N Last Used:</td>
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</tbody>
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Megan’s Law Registrant? Y N Parole/Probation (formal or not): Y N

P.O. Name and Phone Number: __________________________________________________________

Team Support

<table>
<thead>
<tr>
<th>Primary Care Physician:</th>
<th>Phone Number:</th>
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<tbody>
<tr>
<td>Psychiatrist:</td>
<td>Phone Number:</td>
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<tr>
<td>Therapist:</td>
<td>Phone Number:</td>
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<tr>
<td>Social Worker:</td>
<td>Phone Number:</td>
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<tr>
<td>Case Manager:</td>
<td>Phone Number:</td>
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Prepared By: ___________________________ Reviewed By: ___________________________