ADMISSION CRITERIA

1. Homeless, at risk of being homeless, or in a place **NOT FIT** for Human Habitation.
2. Independently able to perform all Activities of Daily Living (ADLs).
3. Independently able use assistive device safely, properly, understands correct use, and without any assistance (wheelchair, cane, walker, etc.).
4. Must be able to ambulate a distance of at least 100 ft. prior to Hospital / facility discharge, with or without assistive device.
5. Able to self-administer medications (with staff oversight)
   (if patient does not have a pharmacy/insurance, the hospital must provide medication upon discharge for the **Full Length of Stay (LOS)**.
6. Must not be incontinent of bladder or bowel.
   (If briefs/diapers are used, client must be able to change independently).
7. Medically and psychiatrically stable at discharge.
8. Alert and oriented to Name, Place, Date, and situation.

WHO IS NOT ELIGIBLE

- Incontinent of bladder and/or bowel (unless Hospice provides Care giver)
- Quadriplegics(unless Hospice provides Care giver)
- Cognitively impaired (unless Hospice provides Care giver)
- Active Tuberculosis/C-DIFF/MRSA of Sputum (or any source)
- Meets admission criteria for SNF/LTC
- Stage 3 or higher decubitus ulcers
- Cardiac EF % < 30. (excluded from Hospice)
- Active substance abuse and not willing to abstain while in the program.

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- Unable to do ADLs, personal care, and medication administration (unless Hospice provides Care giver)
- Unstable medically & psychiatrically
- Combative or aggressive behavior towards staff or other patients while inpatient.
- Actively detoxing (e.g. alcohol, benzos, etc) will need to be stabilize prior to being referred

REFERRAL PROCESS

Referral form be must faxed/e-mailed with supporting documents
(**Face Sheet, H&P, Surgical/PT/Psych notes etc.)**

REFERRAL FAX: 323-998-7614

The Referral Coordinator will determine approval or denial into program.
A reason for denial will be clearly provided. If approved, the Referral Coordinator will coordinate the patient's admission to the Recuperative Care program.

ADDITIONAL DETAILS:

- Referring hospital must fax/ Email a completed "Discharge Checklist" and discharge instructions/summary **prior to hospital/facility release**.
- New clients may arrive between 9am-9pm daily (weekends and holidays.)
- Referring hospital/facility is responsible for client transportation to FT Knox Supportive Housing location.
- Clients must arrive with medications for the **Full Length of Stay (LOS)**, according to discharge instructions. Medications must come with client or prior to client intake.
- Ft Knox Medical Case managers will conduct an intake assessment with all clients. If it is determined that the client is not suitable for our program, client will be returned to the hospital within 36hrs, as indicated in Letter of Agreement (LOA) between the hospital/facility and Fort Knox Supportive Housing.
- Referring hospital/facility must coordinate home health if needed.
  Home health must be set-up prior to Hospital/facility discharge.

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- Clients will also receive a social intake with a case manager within 48hrs of arrival.

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