Hospital to Homeless Service Provider Referral Process

BEFORE YOU START

- The Midnight Mission is a Men's Treatment Facility with a 1 Year Residential Treatment Program structure.
- We do have emergency type overnight shelter in our courtyard; this area is generally not suitable for a patient who has been hospitalized.
- If being discharged with medication to our program we would ask that the patient have a 30 day supply of medication, this would allow us enough time to work with collaborative partners in the community to address any ongoing care including mental health issues.
- Do not drop patients off without written confirmation from The Midnight Mission.

STEP BY STEP PROCESS

1. Upon contact, the Hospital representatives must complete the Hospital to Homeless Service Provider Referral Form (see attached) and fax to (213) 553-2357.
2. The Midnight's hospital liaison will review the completed form and make contact with Hospital representative to determine if the patient is an appropriate referral for our programs.
3. If the patient is an appropriate referral The Midnight's representative will complete the Receiving Facility Section of the Hospital to Homeless Service Provider Referral form with a confirmation number (a unique ID). A copy is faxed to the Hospital Representative.
4. The Midnight's representative will make contact with Hospital representative to coordinate a date and time for a warm hand off.
5. An informational email with the patient's name, date of arrival and name of hospital will go to Recovery Staff, Security, and Public Affairs.
6. Upon arrival, a member of the Recovery staff will be present to receive patient and ensure a smooth transition.

Hospital to Homeless Service Provider Agency Referral Form

Hospital Information

Referring Hospital Name___________________________________

Referring Hospital Staff Name: _____________________________ **Dept:** ______________________

Phone Number: ______________ **Fax Number:** _______________

Receiving Facility Information

Receiving Facility Name: _______________________________ **Fax Number:** ___________________

Receiving Facility Address: ____

Receiving Staff Person Name: ____________________________ **Phone Number:** ________________

Confirmation Number (If applicable): ____________________

Service Provider's Signature of Acceptance: ____

Patient Information

Client Last Name: ________________________________**Client First Name:** ___________________

Last Known Address: __________________________________ **City/St/Zip:** ____________________

Age (If Available): ______________ **Gender (Male/Female):** ___________

Emergency Contact Information (If Available):

Name: __________________________________ **Relationship:** ________________________

Telephone: ______________________________

Does the client have special dietary needs? (Yes/No) _________

If yes, please describe: ____

Is the client ambulatory? (Yes/No) __________

If no, please describe: ____

Does the client have a copy of his/her discharge plan? (Yes / No) _________

Expected Date / Time of Client Arrival: _________________________

Has the client agreed to be transported to named facility? (Yes/No) ________

Client Signature: ____ **Date:** _____________

Hospital Staff Signature: _____________________________________ **Date:** _____________