



**County of Santa Cruz - Health Service Agency  
Homeless Persons Health Project  
Phone: (831) 454-2080; Fax: (831) 454-3424**



**Housing Matters  
Recuperative Care Center  
(831) 458.6020 x1104**

## **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 (HPPH), 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 HPPH. **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 HPPH.

### **What Happens Next?**

The staff at HPPH 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, O<sup>2</sup> 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.



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## 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 a 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-care? Y N      Requires O<sup>2</sup>? Y N      Ambulatory? Y N      Indwelling Catheter? Y N

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.)

Substance Abuse Issues:

Alcohol: Y N      Last Used: \_\_\_\_\_

Drugs: Y N      Last Used: \_\_\_\_\_  
Heroin      Methamphetamine      Cocaine      Opiates      Benzos      Other

Megan's Law Registrant? Y N

Parole/Probation (formal or not): Y N

P.O. Name and Phone Number: \_\_\_\_\_

Team Support

Primary Care Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Psychiatrist: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Therapist: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Social Worker: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Case Manager: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Prepared By: \_\_\_\_\_

Reviewed By: \_\_\_\_\_