



Recuperative Care with HOPE

A SAFE PLACE TO HEAL

What is Recuperative Care?

Recuperative Care with Illumination Health + Home offers short-term medical housing and supportive services for individuals experiencing homelessness who are ready for hospital discharge but need a safe place to recover.

Admission Criteria

TO QUALIFY FOR RECUPERATIVE CARE WITH RHC, A REFERRAL MUST MEET ALL THE FOLLOWING:

- Currently unhoused, at risk of being unhoused, or are living in an inadequate environment post hospitalization
- Medically and psychiatrically stable condition upon discharge
- The patient is AAOx4 (alert and oriented)
- Able to manage ADL (activities of daily living)
- Able to self-administer medications and manage their medication schedule with staff oversight
- Capable of walking 100 ft. with or without DME and able to transfer independently

NOT ELIGIBLE IF:

- Cognitively impaired (i.e., dementia, Alzheimer's)
- Unable to perform activities of daily living
- Unable to transfer, ambulate 100 ft., or use DME independently
- Active infection has not been cleared by a doctor or CID: MRSA, Tuberculosis, C-DIFF
- Non-compliance with detox treatment or a refusal to abstain from substance abuse
- Registered sex offender
- Aggressive or combative behavior directed at staff or other patients



Referral Checklist

- | | |
|---|---|
| <input type="checkbox"/> RHC Health + Home Referral Form | <input type="checkbox"/> Updated Vitals (last 24 hours) |
| <input type="checkbox"/> Client's Demographic Page | <input type="checkbox"/> Medication List |
| <input type="checkbox"/> CalOptima Form/LOA/AUTH | <input type="checkbox"/> PT/OT or Nursing Notes |
| <input type="checkbox"/> H&P (History and Physical) | <input type="checkbox"/> Blood or Wound Culture (if needed) |
| <input type="checkbox"/> Current Progress Notes (if needed) | <input type="checkbox"/> 30-day supply of all medications |

Referral Decision Notification

Once the RHC Health + Home Referral Form has been completed online, emailed or faxed, you will receive notice of confirmation within two hours. A referral coordinator will review and may contact the referring hospital for clarification or to request additional information. A decision regarding approval or denial will be communicated to the referring party within two hours of receiving the referral. If denied, a brief explanation will be provided.



Recuperative Care Referral Form

To refer a patient, please complete and submit this form with supporting documents via email lupefloramoreno@gmail.com or FAX to (323) 588-3336. For referral questions, please contact an RHC Referral Coordinator at (323) 332*2280.

Referring Party

Referring Hospital: _____	Dept/Floor: _____
SW/CM/RN: _____	Phone/Pager #: _____
Email: _____	Nursing Station #: _____
Authorized by: _____	Phone #: _____

Patient Information

Patient Name: _____ MRN: _____ Date of Birth (dd/mm/yyyy): _____
 Gender: Male Female Transgender Other Ethnicity: _____
 Last 4 # of Social Security: xxx-xx- _____ Insurance: _____ Preferred Language: _____
 Housing Situation: Currently Unhoused 4+ episodes of homelessness in the past 3 years

Hospital Admission Details

Chief Complaint Admitting Diagnosis: _____

Any Wounds? Yes No

If yes, explain the number, location, size and stage: _____

Independent with Wound Care? Yes No If no, will Home Health be ordered? Yes No
 Was PPD/TB Test or Chest X-Ray Performed? Yes No If yes, Date: _____ Results: _____

History of Health & Living Situation

Does the patient require or have... (Please circle Y or N and provide explanation accordingly.)

O2	Yes*	No	Active Infection	Yes*	No
*Explain _____			*Explain _____		
Self Administer All Meds	Yes	No*	Ambulatory	Yes	No
Continent of Bowel & Bladder	Yes	No	Assistive Device	Yes*	No
Colostomy/Ileostomy	Yes	No	*Explain _____		
Foley Catheter	Yes	No	Hospice	Yes*	No
Diabetes	Yes	No	*Explain _____		
Insulin	Yes	No	Car	Yes	No
Diabetes related Oral Meds	Yes	No	Service Animal	Yes	No

Behavioral and Mental Health Status

Does the patient have any limitations, behavioral or mental health challenges? No Yes

Mental Health DX If checked, what type? _____
 Non-compliant Forgetful
 Cognitive Impairment Registered Sex Offender
 Other Explain _____

Length of Stay Authorized in Recupertive Care: _____ Days

RHC STAFF ONLY

Date Received: _____
 Approved: Yes* No** *Date: _____ *Authorization #: _____ **Reason for Denial: _____
 Admission Date: _____ Admission Time: _____ Exit Date: _____
 Extension Request: Yes No If YES, Additional Approval Date: _____ by _____ Total LOS _____