



## COVID-19 Prevention Space Referral Form

Form to refer participants from your program who are at high risk for COVID-19 to a non-congregate setting. According to the CDC and FEMA, participants at high risk for COVID-19 are those who are 65 years old or older, or have a compromised immune system, or have an underlying respiratory condition, or have a chronic illness, AND live in a congregate setting.

Please send referrals one at a time via email and include the HMIS ID, if known, in the subject line to:

- [Lorraine.N.Obelcz@phila.gov](mailto:Lorraine.N.Obelcz@phila.gov) and [Emily.Camp-Landis@phila.gov](mailto:Emily.Camp-Landis@phila.gov) for people in congregate programs or people who are unsheltered
- [Michele.Wexler@phila.gov](mailto:Michele.Wexler@phila.gov) for Safe Havens
- [Deanna.Fasano@phila.gov](mailto:Deanna.Fasano@phila.gov) for Journey of Hope
- [Joyce.Sacco@phila.gov](mailto:Joyce.Sacco@phila.gov) for TIP & OAS Recovery Housing

Rec'd by _____
Rec'd date _____ Time _____
Approval _____ Date _____

### 1. Participant information

Name: \_\_\_\_\_ Gender: \_\_\_\_\_ HMIS ID: \_\_\_\_\_

A. DOB: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_

B. Does participant have underlying health condition/s below?  No  Yes

If yes, check all that apply

Respiratory  Immune compromised  Chronic Disease

C. Does participant need assistance with Activities of Daily Living independently?  No  Yes

D. Does participant use assistive devices?  No  Yes

If yes,  Wheelchair  Walker, cane  Hearing aid  Other \_\_\_\_\_

E. Does participant have outside case management or other supports (behavioral health, physical health)?

No  Yes

F. Does participant have any acute medical conditions that need ongoing medical care on site?

No  Yes

If yes, please explain briefly: \_\_\_\_\_

**2. Participant's current residential site information**

Site name: \_\_\_\_\_ Agency Name: \_\_\_\_\_

Residential site type (check one box on chart):      Date began staying at this site: \_\_\_/\_\_\_/\_\_\_

Street or other place not meant for human habitation	<input type="checkbox"/>	Journey of Hope Program	<input type="checkbox"/>
Emergency Shelter	<input type="checkbox"/>	Safe Haven	<input type="checkbox"/>
Transitional Housing	<input type="checkbox"/>	Residential Treatment	<input type="checkbox"/>
Behavioral Health Residence / Program	<input type="checkbox"/>		

Residential Case Manager contact info	
Name:	Agency:
Phone number:	Email:
Residential Case Manager's Supervisor contact info	
Name:	
Phone number:	Email:
Person submitting this application (if different from above)	
Name:	Agency:
Phone number:	Email:

08/19/2020