Catholic Charities

MARIN ◆ SAN FRANCISCO ◆ SAN MATEO

Opened in 1985, Catholic Charities Peter Claver Community marked of the earliest efforts by any organization to aggressively serve those sick and dying from HIV/AIDS. Today, as a comprehensive care residence for 32 previously homeless adults, Peter Claver Community provides medical stabilization and on-site care to low-income San Francisco residents who have disabling HIV/AIDS – most of whom struggle with major co-occurring psychiatric disorders and substance use challenges.

Peter Claver Community Services

Peter Claver Community is a licensed care facility offering:

- Case management
- Medication management
- Residential Nurse care
- Psychosocial care coordination
- Emotional support services
- Dietary services and meals
- Activities
- Socialization opportunities
- Harm reduction
- Counseling
- Connection to other community resources

Peter Claver Community prohibits discrimination based on the fact or perception of race, religion, color, ancestry, age, height, weight, sex, sexual orientation, gender identity, disability, place of birth, creed, national origin, marital status, domestic partner status, or AIDS/HIV status.

An important factor in deciding if Peter Claver Community is an appropriate referral is **that we do not provide long term care or long term housing. We do prioritize clients enrolled in the Certificate of Preference Program; please inform us if your client is a COP holder. More information can be found here: https://sfmohcd.org/certificate-preference.** Please know that once medically optimized, residents are expected to return to the community and referrals will be made to the appropriate level of care.

Please take a few minutes to read the “Admission Procedures” before reviewing the application and criteria. Please feel free to call with any questions about our program.

ADMISSION PROCEDURES

1. **Before beginning the paperwork:**

   Please call ***Stefen Hainbuch, the Peter Claver Community Program Director at (415) 749-3805*** to check on availability of rooms and review the basics of your client's situation. **This may save you a lot of time.**

2. **If referral is appropriate, complete application:**

   Peter Claver: (Fax #) 415-563-3153 or (Email) **shainbuch@catholiccharitiessf.org**

3. **Required for admission:**

□ ***TB Test completed within 90 days of admission***

Accepted: PPD skin test; Chest xray; QuantiFERON-TB Gold test.

□ ***COVID-19 Test completed within 3 days of admission***

□ ***Proof of COVID-19 Vaccine (all doses-including the boosters), (highly encouraged)***

4. **Include additional required information in the application:**

□ ***All pages must be completed (Page 10 is for hospice referrals only). Applications that are not completed, will be returned.***

□ ***Most Recent Medication List***

□ ***History and Physical and/or discharge summary and/or progress notes***

□ ***Provide any documented psychiatric/psychological history***

□ ***Provide DPOA or Advanced Medical Directive paperwork (highly encouraged)***

□ ***Provide a copy of San Francisco DMV ID (or proof of residency)***

□ ***Provide proof of income (most recent)-social security award letter, bank statements, or paystubs***

□ ***The 'Physicians Report for Community Care Facilities' MUST be completed by Medical Provider/MD***

□ ***Completed POLST Form (highly encouraged)***

□ ***Copy of All Insurance Cards***

5. **Upon receipt of the completed application:**
The Program Director and Nurse Case Manager will review the application and discuss appropriateness of applicant for RCFCI level of care. The Program Director will contact you to discuss next steps: Either applicant is ineligible based on application information; additional information may be requested; and an interview date will be scheduled.

6. **Upon acceptance to RCFCIs:**
The Program Director and/or Nurse Case Manager will inform all involved parties of the admission date and procedures.

CRITERIA FOR ADMISSION

Read and fill out this form before filling out our application. We hope it will clarify our admissions criteria and the care needs that can be accommodated at RCFCI and prevent unnecessary paperwork.

Please check off all conditions that apply to your client and read the notes, limitations, and exceptions.

ADMISSION: REQUIRED CRITERIA.

All of the following criteria MUST be met in order to become a resident at Peter Claver.

CRITERIA	√ **all that apply**	**EXCEPTION**	**REASON**
➲ Income is less than $70,600/yearly (**2023)**	☐	No Exception	San Francisco, CA HUD Metro FMR Area/HOPWA
➲ HIV+	☐	No Exception	Mission /HOPWA/CARE
➲ Over 18 years of age	☐	No Exception	Mission /HOPWA/CARE
➲ Capable of signing admissions agreement	☐	If impaired must have Power of Attorney, Conservator, or Next of Kin	Legal
➲ San Francisco Resident	☐	No Exception	HOPWA/CARE Contract
➲ Has San Francisco MD	☐	No Exception. **MD must be willing to follow while at RCFCI.**	HOPWA/CARE Contract

ADMISSION: CARE NEEDS (LIMITATIONS APPLY)

CARE NEEDS REQUIRED	√ all that apply	LIMITATIONS TO ADMISSION	REASON
➲ Requires IV	☐	Can accommodate only if done by an outside home health agency and generally cannot be of more than 2 hour duration OR must be done at a hospital/clinic	Staffing Level/ Licensing
➲ Requires hemodialysis	☐	Can accommodate ONLY if transport is provided by : ◦ Outside agency or friend/family *OR* ◦ Can go alone	Staffing Level/ Lack of Resources
➲ Requires 2+ person transfer	☐	Admission would depend on our ability to provide care safely	Staffing Level
➲ Requires daily/frequent outpatient treatment visits	☐	Can accommodate ONLY if transport is arranged by : ◦ Outside agency or friend/family *AND* ◦ Can go alone *OR* ◦ Has friend/family to escort	Staffing Level/ Lack of Resources
➲ Requires port or line for infusion	☐	Can accommodate if outside provider or home health agency will manage and maintain	RCFCI Licensing
➲ Requires suctioning	☐	Non-emergency suction only *No back-up generator*	Staffing Level
➲ Has diagnosis of MRSA or VRE, C-Difficile or **COVID-19**	☐	**MUST** have letter from MD that treatment was successful and is no longer an infection risk to other residents or staff	Infection Control
➲ Has mental health issues	☐	*If "yes", documentation of psych history required Or may require psychological	Safety / Staffing Level
➲ Uses an electric wheelchair	☐	Requires additional medical provider information and a signed waiver by resident upon admission at Maitri/PCC *(there is a limit of electric wheelchairs allowed at Maitri/PCC at one time)*	Safety
➲ Requires sitters/one to one attention	☐	Cannot accommodate unless 24 hour sitters are provided by family	Safety/ Staffing Level

BARRIERS TO ADMISSION: NO EXCEPTIONS FOR PEOPLE NEEDING THE FOLLOWING:

CARE NEEDS REQUIRED:		NO EXCEPTIONS	REASON
➲ Requires peritoneal dialysis	Cannot admit	**No Exception**	Staffing Model
➲ Requires TPN	Cannot admit	**No Exception**	Staffing Model
➲ Requires ventilator	Cannot admit	**No Exception**	Staffing Model
➲ Has tracheostomy tube	Cannot admit	**No Exception**	Staffing Model
➲ Has stage III or IV pressure ulcer	Cannot admit	**No Exception**	RCFCI Licensing
➲ Requires long term care, acute care, or skilled nursing facility care	Cannot admit	**No Exception**	Mission/Contract Obligations/ RCFCI Licensing
➲ Has Parkinson's or Alzheimer's as **primary diagnosis**	Cannot admit	**No Exception**	RCFCI Licensing
➲ Diagnosed with Advance Dementia	Cannot admit	**No Exception**	Staffing Model/Safety

Referred By: Date:

Agency/Hospital:

Address:

Phone #: Fax #: Pager #:

Cell #: Other #:

CLIENT INFORMATION:

Name:

Ethnicity/Race:

DOB:

Social Security #:

Preferred Pronouns:

Address:

City/St/Zip:

Phone #:

MMN:

Currently at: □ Home
□ Other. Please fill out the following:

Facility: Rm#

Contact:

Phone #: Pgr #:

Address:

Does client have a primary Home Healthcare Agency? If yes, please fill out the following:

Agency:

Contact:

Phone #: Fax #:

Does the client have housing applications in place? If so, list. What is the disposition plan for discharge from RCFCI?

Do you know of other agencies working w/ the client? (Please provide any contact info. you may have)

PERSONAL HISTORY:
Please provide relevant personal history (friends/family involved, prior living situation, etc).

Are there any legal matters pending?

FOR RESPITE REFERRALS ONLY

(required):

Please let us know what the respite goals are for this applicant for their 3-month treatment plan?

PSYCHIATRIC/MENTAL HEALTH HISTORY:

DIAGNOSIS: _____

Currently in Treatment? _____

Provider Name: _____

Provider Phone: _____

ATTACH:

☐ Psychological documentation

☐ History of hospitalizations

SUBSTANCE USE:

Please check one:

□ Active: Used within the last 3 months.
□ Recent: Used within last 3-12 months.
□ Remote: Used one year ago or more.
□ Unknown.
□ No significant substance use (social use, never, etc.)

TYPE OF SUBSTANCE(S) USED:

If actively using:

1. How often:_____

2. Approx. date of last use?_____

3. Interested in treatment? _____

If use was recent, but not currently active, what helped the client to stop using?

HEALTH CARE PROVIDERS:

PRIMARY PHYSICIAN:

NAME _____

Hospital: _____

Address, ZIP:_____

Office #_____Fax# _____

Pager #:_____Other# _____

SECONDARY PHYSICIAN or NP. Include supervising MD if above is not primary MD.

NAME: _____

Address, ZIP: _____

Office #_____Fax#_____

Pager #:_____Other# _____

PHARMACY:_____

Phone#:_____FAX#:_____

PERSONAL / FAMILY CONTACTS:

NAME:_____

Relationship:_____#:_____

Address:_____

City:_____St._____Zip_____

NAME:_____

Relationship:_____#_____

Address:_____

City:_____St._____Zip _____

INSURANCE:

□ **Medi-Cal HMO:** _____

#:_____

□ **Medi-Cal**

#:_____

Issue Date:_____

□ **MediCare**:

#::_____

□ **Medicare "D"** Prescription plan information:

_____

□ **Healthy SF #:**_____

□ **Private Insurance/VA/Other**: _____

#_____

DURABLE POWER(S) OF ATTORNEY

Please attach copies of current/active appointee(s) or let us know who to contact for a copy.

□ **HEALTH CARE**: Please attach copy.

Name:_____

Address:_____

City/St/ZIP:_____

Work # _____

Home #_____

□ **FINANCES**: Please attach copy.

Name:_____

Address:_____

City/St/ZIP:_____

Work #_____

Home #_____

To: Physician / Health Care Provider Re: Peter Claver Community Application

Admission to Peter Claver Community requires this information

NAME OF CLIENT:	
HIV STATUS	**T-CELL / VIRAL LOAD COUNTS**
1. Year first tested HIV positive (if known): _____ 2. Year first diagnosed with AIDS (if known):_____ 3. Please check appropriate category: □ HIV+ □ Disabling HIV □ AIDS □ Disabling AIDS Diagnosis	1. T-Cell Information: a. Date of last count:_____ b. Last count #:_____ 2. NADIR of CD4, if known: _____ 3. Viral Load Information: a. Date of last count:_____ b. Last count #:_____

♦ **Required Health Care Provider Information (MD, PA, NA)**

I am treating the person named above for symptoms/conditions related to HIV/AIDS

X_____ Date

X _____ License #

X_____ Signature of Health Care Provider (MD, PA, NP)

X _____ Print Name

X_____ Phone #

X _____ Pager #

FINANCIAL INFORMATION

Service Fees are 60% of the resident's monthly income. 30% is dedicated to rent and the other 30% is dedicated to offset the cost of high-level care and services at RCFCIs.

Does applicant utilize money management assistance from a friend, family member or agency?	
MONEY MANAGEMENT AGENCY OR OTHER:	**CONTACT INFORMATION:**
Name of agency: _____	Phone:_____
Contact: _____	Phone: _____

SOURCES OF INCOME:

MONTHLY SOURCE OF INCOME:	**AMOUNT OF INCOME:**
SSDI: Social Security Disability Insurance	$
SSI: Supplemental security income	$
RSDI: Social Security Retirement Benefits	$
SDI: State Disability Benefits	$
Private Disability	$:
Private Retirement/Pension	$
Other	$
TOTAL:	$

MONTHLY EXPENSES:

MONTHLY MEDICAL & RENT EXPENSES	**AMOUNT OF EXPENSE**
Insurance Premium	$
Medications /co-pays	$
Rent	$
TOTAL	$

AUTHORIZATION TO OBTAIN FINANCIAL INFORMATION:
I hereby authorize Maitri and Peter Claver Community to obtain financial information in order to determine my room and services fee.

X _____ _____
Signature of applicant or DPOA Print name

_____
Date

****Acceptable proof of income from within the past <u>6 months</u> only:**

Letter from Social Security
Bank Statement
Deposit Record from Money Management Agency
Copy of Check

AUTHORIZATION TO EXCHANGE CONFIDENTIAL INFORMATION

Please note that separate forms must be used for each specified contact

It is the policy of Peter Claver Community to hold all information about clients as confidential and to not release informationwithout permission. In order to facilitate your application process we need permission to contact your providers and to get information about your physical and mental health.

I,_____, hereby give my permission to obtain or disclose my private health information for the purpose of admission to the Maitri/Peter Claver Community. This authorization is valid for the duration of the intake process.

While it is your right to limit or exclude information from disclosure, this authorization is for full <u>disclosure of all records</u>, including diagnosis, treatment, assessment, dates of hospitalizations, mental health/psychiatric conditions, HIV/AIDS testing results, drug and alcohol information, and sexually transmitted disease information.

You may revoke your consent at any time.

You have the right to a copy of this authorization.

Your confidential information is protected by the Federal Privacy Act and California Law.

Unless otherwise noted, this authorization expires in one year from the date of signature.

_____

*Name of Agency (or Individual) to be contacted

X_____X _____

Signature of Client or Representative Date