



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 RCFC 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 RCFCs:

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.
 [Redacted]

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

L	<input type="checkbox"/>		
	<input type="checkbox"/>		
➡	<input type="checkbox"/>		
➡	<input type="checkbox"/>		

ADMISSION: CARE NEEDS (LIMITATIONS APPLY)			
CARE NEEDS REQUIRED	<input type="checkbox"/> all that apply	LIMITATIONS TO ADMISSION	REASON
➤ Requires IV	<input type="checkbox"/>	Can accommodate only if done by an <u>outside home health agency</u> and generally cannot be of more than 2 hour duration OR must be done at a hospital/clinic	Staffing Level/ Licensing
➤ Requires hemodialysis	<input type="checkbox"/>	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	<input type="checkbox"/>	Admission would depend on our ability to provide care safely	Staffing Level
➤ Requires daily/frequent outpatient treatment visits	<input type="checkbox"/>	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	<input type="checkbox"/>	Can accommodate if outside provider or home health agency will manage and maintain	RCFCI Licensing
➤ Requires suctioning	<input type="checkbox"/>	Non-emergency suction only <i>No back-up generator</i>	Staffing Level
➤ Has diagnosis of MRSA or VRE, C-Difficile or COVID-19	<input type="checkbox"/>	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	<input type="checkbox"/>	*If “yes”, documentation of psych history required Or may require psychological	Safety / Staffing Level
➤ Uses an electric wheelchair	<input type="checkbox"/>	Requires additional medical provider information and a signed waiver by resident upon admission at Maitri/PCC <i>(there is a limit of electric wheelchairs allowed at Maitri/PCC at one time)</i>	Safety
➤ Requires sitters/one to one attention	<input type="checkbox"/>	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: <input type="checkbox"/> Home <input type="checkbox"/> 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:
<p>PRIMARY PHYSICIAN:</p> <p>NAME _____</p> <p>Hospital: _____</p> <p>Address, ZIP: _____</p> <p>Office # _____ Fax# _____</p> <p>Pager #: _____ Other# _____</p> <p>SECONDARY PHYSICIAN or NP. Include supervising MD if above is not primary MD.</p> <p>NAME: _____</p> <p>Address, ZIP: _____</p> <p>Office # _____ Fax# _____</p> <p>Pager #: _____ Other# _____</p> <p>PHARMACY: _____</p> <p>Phone#: _____ FAX#: _____</p>

INSURANCE:
<p><input type="checkbox"/> Medi-Cal HMO: _____</p> <p>#: _____</p> <p><input type="checkbox"/> Medi-Cal</p> <p>#: _____</p> <p>Issue Date: _____</p> <p><input type="checkbox"/> MediCare:</p> <p>#: _____</p> <p><input type="checkbox"/> Medicare "D" Prescription plan information:</p> <p>_____</p> <p><input type="checkbox"/> Healthy SF #: _____</p> <p><input type="checkbox"/> Private Insurance/VA/Other: _____</p> <p># _____</p>

DURABLE POWER(S) OF ATTORNEY
<p>Please attach copies of current/active appointee(s) or let us know who to contact for a copy.</p> <p><input type="checkbox"/> HEALTH CARE: Please attach copy.</p> <p>Name: _____</p> <p>Address: _____</p> <p>City/St/ZIP: _____</p> <p>Work # _____</p> <p>Home # _____</p> <p><input type="checkbox"/> FINANCES: Please attach copy.</p> <p>Name: _____</p> <p>Address: _____</p> <p>City/St/ZIP: _____</p> <p>Work # _____</p> <p>Home # _____</p>

PERSONAL / FAMILY CONTACTS:
<p>NAME: _____</p> <p>Relationship: _____ #: _____</p> <p>Address: _____</p> <p>City: _____ St. _____ Zip _____</p> <p>NAME: _____</p> <p>Relationship: _____ # _____</p> <p>Address: _____</p> <p>City: _____ St. _____ Zip _____</p>

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: <input type="checkbox"/> HIV+ <input type="checkbox"/> Disabling HIV <input type="checkbox"/> AIDS <input type="checkbox"/> 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 #

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 information without 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 disclosure of all records, 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