

# Alameda County Hotel Screening & Referral Form

\* Required

## Hotel Screening & Referral

Referring Organization/Institution \*

Your answer

Form Completed By (First & Last Name) \*

Your answer

Referring Provider's Phone \*

Your answer

Client First & Last Name \*

Your answer

Client Phone

Your answer

Client DOB \*

MM DD YYYY

\_\_ / \_\_ / 2020

Client SSN

Your answer

Client Monthly Income

Your answer

Income Source

Your answer

Covered by Health Insurance? \*

Choose



If yes, what is their primary insurance?

Your answer

Secondary insurance?

Your answer

Client Contact 1

Enter Contact First & Last Name, Phone, and Relationship to Client

Your answer

Client Contact 2

Enter Contact First & Last Name, Phone, and Relationship to Client

Your answer

Is the client actively expressing suicidal/homicidal ideation? \*

Yes

No

Must have at least one in EACH category below (Residential and Clinical)

Current Residential Status - at least one: \*

Living on the street/place not meant for habitation

Emergency Shelter

Transitional housing program for individuals experiencing homelessness

Exiting a healthcare or other institution with no identified residence at time of discharge

In a congregate living situation (in the last 90 days) with no way to self-isolate AND homeless prior to entry

Current Clinical Status - at least one: \*

Positive COVID-19 test

Recent contact with someone who has verified positive COVID-19 test

Suspected case based on pending test result (awaiting lab confirmation)

Suspected case based on symptoms (fever, cough, AND shortness of breath)

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### Referral Information & Agreement

It is important guests are advised of the rules and intake process prior to coming to the hotel. Our goal is to give important information to support their success entering the program. This can only be if you, our referring partners, take time to review at the time of referral.

I have advised the patient there is an intake process that includes security and screening. \*

The referral can only be accepted if "Yes" is selected

Yes

No

The patient has agreed to the Safety and Participation Agreement. \*

The referral can only be accepted if "Yes" is selected

Yes

No

Staff Signature Name \*

Your answer

Staff Signature Date \*

MM DD YYYY

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Send me a copy of my responses.

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