



COVID-19 Shelter Referral Form

This form is for individuals experiencing homelessness that need either congregate or non-congregate (motel) shelter.

For questions please e-mail: COVID-19HomelessResponse@santacruzcounty.us

Date and Time of Referral: _____

Referred by: _____
Name Organization/Shelter Phone Number

Client Name: _____ DOB: _____ Age: _____

Spoken Language: _____ Date of Symptom Onset (if applicable): _____

Client's Priority Level (Please note, priority 4 persons are accepted *only* as space/need allows):

PRIORITY 1 - Persons experiencing homelessness that are **confirmed COVID-19 positive**

Date of positive test _____

Date of symptoms onset _____

PRIORITY 2 - Persons experiencing homelessness that are **presumed COVID-19 positive** (Client has COVID-19 symptoms **and** has been in known contact with COVID-19 positive individuals)

Date of contact with COVID-19 positive person _____

PRIORITY 3 - Persons experiencing homelessness who public health would advise to self-quarantine because either of the following (check only one):

Client has COVID-19 symptoms

Client has had significant contact with COVID-19 positive individuals

Date of contact with COVID-19 positive person _____

Date of symptoms onset _____

PRIORITY 4 - Persons experiencing homelessness that are **elderly (65+ years old) or medically vulnerable**. Explain client's medical vulnerability:

PRIORITY 5 - All other homeless individuals that do not meet the criteria required for priorities 1-4.

Is Client a veteran? Yes No Is Client a veteran dependent/survivor? Yes No

Client Location - Where can client be found so that they can be transported to a Shelter in Place location?

Please be as descriptive as possible, use back of form if additional space needed:

Client Phone: _____ Client Email: _____

Someone that can relay message to client: _____
Name Phone



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For **Priority 4** clients, please list any people who the client could share a hotel room. Use back of form if additional space needed.

Name: _____ Age: _____ Relationship: _____ Have/will have referral

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Medical Condition/Needs

Summary of medical condition and issues:

Physical Disabilities: _____ Chronic Health Issues: _____

Communication Issues (hearing, vision): _____ TBI or Cognitive Issues: _____

Does Client require ADA unit? Yes No Does Client smoke? Yes No

Known allergies (medication, food, other): _____

Assistive Devices: Yes: _____ No Requires Insulin: Yes No

Self Care: Yes No Incontinent? Yes No Special Med. Requirements: _____

Mental Health Diagnosis/Concerns: Yes: _____ No

Known Substance Abuse Issues: Yes: _____ No

Person Under Investigation? Yes No Pet? Yes No If yes, type: _____

Prefer North or South County? North South No preference

Care Team/Support

Primary Care Physician: _____ Phone Number: _____

Social Worker: _____ Phone Number: _____

Case Manager: _____ Phone Number: _____

Therapist/Psychiatrist: _____ Phone Number: _____

Treatment Program: _____ Phone Number: _____

Insurance (if known): _____

Additional Information – Use this space to write anything else pertinent to know for this referral: