SAMARITAN HOUSE SCREENING EVALUATION

Samaritan House is a respite safe haven for underserved homeless adult populations who need to recuperate post hospital treatment or post surgery for up to 10 days. Guests receive 24 hour accommodations and three meals a day. Admission is on referral from hospitals and reliable medical providers. Guests are served on a first come, first serve basis when eligibility requirements are met.

*We are a non-medical program, guests must be self-medicating and ambulatory
*Carefully evaluate each person for compliance with our guidelines and rules
(Samaritan House IS NOT able to accept patients requiring oxygen, colostomy or and IV)
*If patient will require nursing home or extended stay placement, this must be arranged before we can approve the patient's stay at Samaritan House.
*Reservations for future stay are not possible

Directions: Please fill out this form and fax it to Samaritan House #704-659-4174
Samaritan House personnel will evaluate the appropriateness of your patient. We will contact you by phone stating approval or not. Samaritan House will pick up patient before 3:00pm (Mon.-Fri.)
Intake Hours: Monday – Friday 9:00am – 2:00pm

Patient Name:_______________________________________ Date of Birth: ____/____/____

Social Security #:______-_____-________ Recuperation Days Needed (up to 10 days):__________

Diagnosis / Nature of Illness or Injury:____

Recuperative Care Needs:____

Does the patient have long care needs?: Yes____ No____ (If "Yes", see **below)

Does the patient have a mental illness for which he/she receives treatment? ___Yes ___No

Has he/she been on psychotropic medications for at least 21 days? ___Yes ___No

Is the patient currently taking Methadone? ___Yes ___No

(**Samaritan House CANNOT accept patients currently taking Methadone)**

Is the patient awake, alert and oriented? ___Yes ___No

Is the patient's behavior appropriate for group living situations? ___Yes ___No

Can the patient perform activities of daily living without assistance? ___Yes ___No

(This includes bathing, bathroom use, eating, etc.)

Is the patient able to manage his/her own care including dressing changes? ___Yes ___No

If not, what arrangements have been made for dressing changes?

____

GUEST MUST HAVE ALL MEDICATIONS**

Social Worker/Nurse: Please complete the following section BEFORE sending

Does the patient have an approved nursing home or extended care facility bed? ___Yes ___No

If "Yes": Name of social worker:__________________Case #:__________________

Date patient will enter nursing home or extended care facility: ____/____/____

Facility:______________________________________ Phone #:________________

Referring facility:____

By: (Person completing this form):______________________________________Date:____/____/____

Phone #: (____)________________ Fax #: (____)________________

For Samaritan House Use Only:

APPROVED_____ NOT APPROVED_____ Reason:____________________________________

Signed By:____ Date:____/____/_____