Open Door Mission Respite Eligibility Criteria

Admission Criteria

1. Patient must have Presumed Indigent, HFAP, Homeless Grant, or other financial eligibility that is in-network with the Open-Door Mission Healthcare for the Homeless on-site clinic.
2. Must have proper picture identification
3. Must be male, and at least 18 years of age
4. Must be medically and psychiatrically stable
    - Psychiatrically stable enough to accept and receive care and not interrupt the care of others
5. Must be agreeable to program requirements and behavior agreements
6. Patient has an acute medical need requiring respite care
    - An acute or post-acute medical illness which requires short-term resolution and care or need an environment in which to prepare for or recover from medical procedures (i.e., surgery, chemotherapy, radiation, endoscopy)
7. Patient is free from communicable diseases other than HIV, or AIDS
    - A negative COVID-19 PCR test result not older than 48 hours is needed prior to admission
    - A negative TB test result is needed prior to admission
8. Must be able to manage own medications, medical equipment and be independent with all ADLs (depending, ADL's will be taken on a case-by-case basis)
    - Must be able to navigate Open Door Mission campus
    - Ability to dress, bathe, transfer, and ambulate independently or with mechanical assistance such as a wheelchair, crutches, or cane
9. Patient must be provided with at least a 30-day supply of medications, prescription refills, and discharge papers upon exit from hospital
10. Patient is not a registered sex offender

Exclusionary Criteria

1. Person is experiencing fecal incontinence
2. Open Door Mission determines that a person is a registered sex offender or has active felony warrants
3. Person has communicable disease other than HIV or AIDS
4. Person has made a suicide attempt within the last 30-45 days
5. Person is unable to perform ADLs (will make exceptions, please inquire)
6. Person has severe cognitive deficits/dementia
7. Either party has observed recent uncontrolled violent behavior by the person
8. Person is a fugitive
9. Person has previously been restricted from returning by Open Door Mission
10. No history of violent, criminal, or destructive behavior in the last 3 years
    - Willing to consider extenuating circumstances on a case-by case basis, such as if a patient is truly remorseful or was poorly represented in court
11. Patients that require IV antibiotics (External Only)

Please note: The above requirements are not an all-inclusive list.
Patients who are sent to the Medical Respite Program at Open Door Mission (ODM) that do not meet all eligibility requirements will be sent back to referring institution.

In addition to passing all eligibility requirements, the following steps must be completed before any patient will be admitted to the Medical Respite Program at ODM
☐ It is recommended to first check on bed availability: call Medical Respite at 832-962-4245, Monday-Thursday from 8AM to 4PM.
☐ Complete Authorization of Criminal Background Check (This is a Release of Information signed by the patient giving consent to conduct a criminal background check by Open Door Mission) ☐ Cover sheet ☐ Completed referral form ☐ Face Sheet ☐ History & Physical, and any other applicable documentation (progress notes, PT/OT evaluations) that can help us make an informed decision. ☐ Email to rmarino@opendoorhouston.org, Attn: Medical Respite
☐ Admissions to Medical Respite are Monday-Thursday from 8AM to 4 PM. Patients must arrive with discharge papers, a two-week supply of medication, and follow-up appointments/home health visits arranged.

Open Door Mission

Criminal Background Check Authorization

Print Name: _____
(First) (Middle) (Last)

Former Name(s) and Aliases: _____

DOB:_____ Race/Ethnicity:_____

Driver's License Number or ID: _____ State: _____

Social Security #_____

List ALL states that you have lived in since the age of 18:

_____
_____
_____

I hereby authorize OPEN DOOR MISSION and its designated representatives to conduct a criminal background check as a part of my condition to be accepted in to the Respite program. I understand that the scope of the background check may include civil and criminal history records from any criminal justice agency in any or all federal, state, county jurisdictions.
I understand that if I refuse to authorize a background check or falsify any information, I will not be eligible to participate in any program offered by OPEN DOOR MISSION. The information contained in this application is correct to the best of my knowledge.

Signature: _____ Date:_____
Witness: _____ Date:_____
2nd Witness (for phone consent): _____ Date:_____

ODM Respite Care Cover Sheet

Contact Information: kvann@opendoorhouston.org
832.962.4266

The Medical Respite Program at Open Door Mission (ODM) provides shelter and meals to patients who need a safe place to continue to heal after release from hospital or to prepare for a procedure at a hospital. The Medical Respite Program is ***NOT*** staffed by medical personnel. Referred patients must meet all eligibility requirements on referral form.

Referring agency name _____Staff name _____
Phone number _____Fax number_____
Referring staff email _____

Patient Name _____DOB_____

Patient must arrive with:

- ✈ Discharge papers
- ✈ At least a two-week supply of medications, with refills as needed
- ✈ Scheduled follow-up appointment with primary care provider
- ✈ Home Health services pre-arranged, if needed
- ✈ Negative COVID-19 test result within 72 hours prior to arrival date

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Open Door Mission Respite staff only

Cleared for Medical Respite?

- ✈ Yes, Intake approved for _____/_____/_____for _____ days.
- ✈ No,
- ✈ Not Eligible to Return to ODM
- ✈ No Medical Respite beds available
- ✈ Requires a level of care that is inappropriate for the ODM Respite Program
- ✈ Patient did not arrive at ODM from hospital with proper approval
- ✈ Other _____

Legal clearance determined? (Background check completed): ☐ Yes ☐ No

Open Door Mission Respite Referral Form

Referring Institution Information

Referring Provider Name:		
Address:	City:	Zip:
Phone:	Email:	
Patient's Name (first, middle, last):	Preferred Name:	
DOB:	Gender:	
Primary Language:	Previous Living Situation:	
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widow(er)		
Military Service ☐ Yes ☐ No	Hospice Client ☐ Yes ☐ No	

Medical Information

Primary Care Provider	Clinic Name	
Address:	City: Zip:	
Contact:	Phone:	Email:
List acute medical need (reason why patient requires respite care)		
Current medical diagnoses (only include diagnoses made by licensed medical professionals)		
Current Medications	Dosage	
Ambulatory? ☐ Yes ☐ No	Can patient manage their medications? ☐Yes ☐ No	
List mobility restrictions (wheelchair, walker, cane, etc.)		

Does this patient have any allergies/dietary restrictions?
Is patient's pain controlled with oral medications? ☐ Yes ☐ No
Any history of abuse of pain medications? ☐ Yes ☐ No
Is the patient experiencing detox? ☐ Yes ☐ No *(We do not provide detox)*
Is patient appropriate for communal environment? ☐ Yes ☐ No

Will Home Health/DME be ordered for this patient? ☐ Yes ☐ No	Provider Name and Number
Is patient a trauma victim? ☐ Yes ☐ No	
Does patient have history of psychotic episodes? ☐ Yes ☐ No	
Has patient experienced any seizures in last 30 days? ☐ Yes ☐ No	
Is the patient agreeable to coming to Medical Respite? ☐ Yes ☐ No	
What is the patient's housing plans after Medical Respite?	

External Referring Agencies Only

Will the patient have at least a 30-day supply of medications? ☐ Yes ☐ No	
Will the patient require wound care? If yes, a 30-day supply should be provided to the patient. ☐ Yes ☐ No	
Will home health/DME been required for the patient? ☐ Yes ☐ No If yes, please ensure visits have been arranged.	Provider name and number.
Will the patient require follow-up appointments? ☐ Yes ☐ No If yes, please ensure appointments are scheduled prior to discharge.	

All Referring Agencies (Required)

Please provide contact information if additional clinical clarity is needed (RN/SW)

Please complete form and email to **rmarino@opendoorhouston.org**

Signatures

By signing below, I certify that the above information is true and correct.		
Print name	Signature	Date
Position Title	Referring Institution & Phone Number	