



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: rmarino@opendoorhouston.org

(Rachel Marino) 832.962.4245

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

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 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow(er)		
Military Service <input type="checkbox"/> Yes <input type="checkbox"/> No Hospice Client <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Can patient manage their medications? <input type="checkbox"/> Yes <input type="checkbox"/> No	
List mobility restrictions (wheelchair, walker, cane, etc.)		

Does this patient have any allergies/dietary restrictions?	
Is patient's pain controlled with oral medications? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Any history of abuse of pain medications? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is the patient experiencing detox? <input type="checkbox"/> Yes <input type="checkbox"/> No (<i>We do not provide detox</i>)	
Is patient appropriate for communal environment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Will Home Health/DME be ordered for this patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Provider Name and Number
Is patient a trauma victim? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does patient have history of psychotic episodes? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Has patient experienced any seizures in last 30 days? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is the patient agreeable to coming to Medical Respite? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Will the patient require wound care? If yes, a 30-day supply should be provided to the patient. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Will home health/DME been required for the patient? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please ensure visits have been arranged.	Provider name and number.
Will the patient require follow-up appointments? <input type="checkbox"/> Yes <input type="checkbox"/> 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	