COVID-19 Medical Respite Center Referral Protocol

****For Shelter and Outreach Staff****

1. **Obtain verbal consent from the client to share information with Equitable Social Solutions, Dane County Human Services, and Public Health Madison & Dane County.** Equitable Social Solutions (Equus), in partnership with Dane County, will initially authorize the stay at the Medical Respite Center. The duration of stay will be determined based on the test results and current recommendations from the CDC. Therefore, the client must agree to share necessary medical information with Equitable Social Solutions Counseling, Dane County Human Services, and Public Health Madison & Dane County.
2. **Review the entire *Medical Respite Center Participant Agreement Form* with the client and ask to sign** (verbal signatures will be accepted if you are in telephone contact with the client).

3. **Send the *Medical Respite Center Referral Form* and signed *Participant Agreement Form* to Equitable Social Solutions Counseling with a subject line "Medical Respite Center Referral".**
    - Email: intakes.referrals@equitablesolutions.com
    - (via encrypted email when possible)

4. **Call to alert the Equus staff on call about the referral.** If approved, Equus staff will contact the hotel, arrange for a room, and then relay the hotel information to the referring staff. Staff will strive to respond with details within 30 minutes. **If you do not hear back within 30 minutes, call again.**

    - Call Equus 24 hours a day at: 608-618-0216 or 608.216.2000.
    - Emergency contact: Marek Lagoda, Equitable Social Solution: 262.498.3402

5. **Arrange transportation to the hotel for the client.** Provide a mask and ensure the client washes their hands for the ride. The client should be transported directly to the designated hotel from the hospital or shelter.

Public Health
MADISON & DANE COUNTY
Healthy people. Healthy places.

COVID-19 Medical Respite Center Referral Form

DANE COUNTY
DEPARTMENT OF HUMAN SERVICES

Send To: Equitable Social Solutions (Subject: Medical Respite Center)

- Email: intakes.referrals@equitablesolutions.com

And Call: Equitable Social Solutions

- Phone: 608-618-0216 or 608.216.2000 (24 hours a day)

Note: Self referrals are not allowed; only Shelter and Outreach staff can make a referral

Referred Client Name:_____ DOB: _____

Client contact phone or email:_____

Referring Provider Agency and Program: _____

Staff: _____

Call back phone: _____

☐ **Patient requires ISOLATION**
(Has positive COVID19 test or symptoms of COVID19)

****Equitable Social Solutions staff: place on 3rd floor of MRC****

Date Tested (if available): _____

Test Result (if available): _____

☐ **Patient requires QUARANTINE**
(Had significant exposure to COVID19; not exhibiting symptoms)

In order to be referred for quarantine, a contact to a positive case must be validated by the referral source or had been identified through contact tracing.

****Equitable Social Solutions staff: place on 2nd floor of MRC****

Date of last exposure to COVID19:

_____

Food allergies: _____

Needs interpreter? ☐Yes ☐No If yes, what language: _____

Other special needs: _____

The client listed above was screened for symptoms of COVID19 or was identified as a contact to case and therefore requires either isolation or quarantine. I have reviewed the Participant Agreement with the client and obtained consent from the client to share information with Equitable Social Solutions, Dane County Human Services, and Public Health Madison & Dane County.

Healthcare Provider Contacted: _____

Referring Provider Signature:_____ **Date:** _____

Print Provider Name: _____

COVID-19 Medical Respite Center Participant Agreement

Welcome! You are being offered a medical respite center hotel voucher to help you rest and recover while awaiting Coronavirus (COVID-19) test results or recovering from COVID-19. Your stay will be at the following location:

Quality Inn
Address: 1754 Thierer Rd.
Madison, WI 53704
Phone: (608) 640-4660

The site operator, Equitable Social Solutions, in consultation with Public Health Madison and Dane County, will determine when you are cleared to leave the facility. You will be informed of your discharge date by onsite staff. Discharge will occur when: you complete the isolation or quarantine requirements OR it is determined you do not have COVID19.

I understand that I have the following responsibilities as a participant of the Medical Respite Center:

☐ I am expected to practice self-isolation while using a COVID-19 Hotel Voucher, including:

- Maintaining a distance of 6 feet or more from other people
- Refraining from having any visitors
- Refraining from congregating in public spaces
- Engaging in regular and thorough hand-washing
- Wearing a mask if out of my room or staff are in my room
- Remaining in my room except for essential trips, including smoke breaks.

☐ The following **consequences** will occur if I do not adhere to the shelter-in-place order:

- If I am seen leaving the room (for non-essential trips), allowing a visitor in my room, or not maintaining social distance, I will receive a verbal warning. Any visitors will be asked to leave.
- If this happens again, I will receive a written warning that I have violated the order and staff will attempt to resolve the issue.
- If there is a third infraction, I may be required to leave.

☐ I understand that the following behaviors will result in **immediate discharge**: verbal or physical violence or threats of violence, destruction of property, possession of weapons (including knives over 2 inches), theft, selling drugs on the hotel premises, and harassment of any kind (including sexual harassment). I understand that any behavior that endangers the health or safety of guests or staff including behaviors not listed above and repeated interference with the rights of other guests to peaceful enjoyment of the facility will not be tolerated and result in being asked to leave the hotel.

Serious threats or acts of violence will also lead to not being allowed to return to the Medical Respite Center in the future.

☐ **Meals** will be delivered to my room at 9:00 AM, 12:00 PM, and 6:00 PM. I understand that I need to be in my room during meal times to receive the food and not leave it in the hallways.

☐ I understand that Equitable Social Solutions staff may visit me as much as twice per day. Onsite staff can assist with non-clinical needs like clothing, substance abuse support,and mental wellness support. I may also receive calls from Public Health Madison and Dane County staff to assist with symptom monitoring.

☐ For fire safety reasons, **smoking** is not allowed inside the hotel or near hotel entrances. Participants are able to smoke at a designated area 15 feet away from the main entrance of the building. Please dispose of smoking materials properly.

☐ It is my responsibility to store my medications **securely** in my room. I will speak with staff if I am uncertain about how to do this.

☐ I understand that staff can supply me with comfort items such as: acetaminophen for headache and high fever, cough drops, gloves, disposable masks, and personal use items/toiletries. I acknowledge that these items are to be used at my discretion and I can ask for them if I need them.

☐ I understand that a **red box** can be placed in my room to use for safe disposal of needles and other IV-drug paraphernalia. If I need a red box I will ask for one. I WILL NOT try to open or destroy the red box under any circumstances. New needles can be provided to me by Equitable Social Solutions staff if I need them.

☐ The Equitable Social Solutions staff and the hotel are not responsible for any of **my items or belongings that are lost, stolen, or damaged**. I have been advised not to keep valuable items or large amounts of money with me at the hotel.

☐ I agree not to move or remove **furniture** from my room. I also agree not to bring furniture or other larger items into my room.

☐ Hotel staff will not be cleaning my room during my stay and it is my responsibility to place my bedding and towels in a plastic bag outside my door for cleaning, and alert the front desk that I need new linens. I will receive clean linens, and I will be responsible for making my bed, cleaning surfaces, and maintaining cleanliness of my room otherwise. I agree to refrain from collecting items. I agree to return all bed linens, pillows, and towels to hotel staff and to **leave my room clean** when I exit the hotel.

☐ If I leave the premises for **more than 72 hours**, I will be discharged from the hotel and my room will be provided to another guest.

☐ I understand that any **personal belongings** I leave behind will be stored for 7 days, then discarded.

☐ If I leave premises and I am deemed still **contagious**, shelters will be notified and I will not be allowed into any shelter setting until I am medically cleared.

☐ If staff are aware that I am facing a **medical emergency**, staff will call 911 to access medical assistance for me. I understand that staff will share the "emergency information" I provided at intake with the responding emergency personnel. This includes paramedics, fire responders, law enforcement, and any other emergency personnel.

☐ I consent to staff contacting the **emergency contact** I provided at intake. I may revoke this authorization at any time by communicating with Equitable Social Solutions.

☐ In the event of an emergency, I should walk calmly to an exit, staying at least 6 feet away from all other residents, and **evacuate** the building as quickly as possible. In case of fire, use the clearly marked designated fire exits. Once everyone has reached the assembly site, everyone must report to staff so they can verify that all residents are accounted for.

☐ If I have **any needs or questions** during my stay, I will reach out to the program staff or the front desk.

I have carefully read and fully understand all the provisions of this form. I am freely, knowingly, and voluntarily signing this form. I hereby release the facility, its employees, volunteers, and officers, as well as any of their assigns or designees on behalf of myself, my family, my estate, and anyone else affiliated or associated with me or representing me, from all liability arising as a result of my stay in the medical respite facility to the fullest extent permitted by law.

Participant Signature: _____ **Date:** _____