**Boston Medical Center**
**Doctor's Office Building, Suite 707**
**720 Harrison Ave**
**Boston, MA 02118**

The Elders Living At Home Program at Boston Medical Center provides support and intensive case management services to individuals who are homeless, or who are at imminent risk of losing their housing. ELAHP clients are usually followed for 6-12 months, although in some instances individuals requiring stabilization may be followed for a longer period of time.

**ELAHP can take referrals for INDIVIDUALS who are either:**

- Homeless
- At risk of losing their housing.

**ELAHP CANNOT TAKE REFERRALS FOR REGISTERED SEX OFFENDERS**

**How to make a referral to ELAHP:**

1. Complete the ELAHP referral form on the following page.
2. Attach any pertinent information/documentation.
3. Fax referral to Kip Langello, ELAHP Program Manager at 617-638-6175.

**What happens after a referral to ELAHP has been made:**

1. Referral will be reviewed and referrer will be contacted. Due to high volume of referrals, it could take a couple weeks to hear back from ELAHP. If you do not hear from ELAHP, or if it is regarding an IMMINENT EVECTION please call to confirm that the referral has been received.
2. ELAHP may contact the client for more information, so please make sure the client knows that he/she is being referred to ELAHP.
3. The referring person should fill out the referral form. The client SHOULD NOT FILL OUT THE FORM THEMSELVES.
4. If the referral has been accepted, the client will be assigned to an ELAHP case manager.
5. Referrals are prioritized in the following order:
   a. People facing imminent eviction or loss of housing WILL HAVE FIRST PRIORITY
   b. People who are living in homeless shelters or on the street WILL HAVE SECOND PRIORITY
   c. People who are housed, doubled up or homeless but living with family or friends WILL HAVE LOWER PRIORITY

**For more information, call or email Kip Langello at 617-414-1642 or kip.langello@bmc.org**

ELDERS LIVING AT HOME PROGRAM
HEALTH, HOUSING, AND HOPE 30 YEARS

BOSTON MEDICAL CENTER
EXCEPTIONAL CARE. WITHOUT EXCEPTION.

## Elders Living At Home Program REFERRAL

If facing IMMINENT eviction, check this box ☐

Date of referral: _____

Client's Name: _____ Phone _____

Address or where client is staying:_____

DOB: _____ Age: _____

Gender: ☐ Male ☐ Female ☐ Transgender

Citizen/Legal Resident: ☐Yes ☐No ☐Decline to answer Veteran: ☐Yes ☐No

Does client speak English. ☐Yes ☐No If no, what language?_____

Disabled: ☐ Yes ☐ No If yes, disability_____

Income Source: _____ Income Amount: _____

Reason(s) for referral:

☐ Person is homeless and in a shelter
☐ Person is homeless and not in a shelter
☐ Person at risk for losing housing (eviction)
☐ Housing stabilization
☐ Other

Can client read/understand WRITTEN applications, documents, etc.? ☐ Yes ☐ No

For statistical purposes only
Hispanic/Latino: ☐Yes ☐No
Race: ☐ Black/African American ☐ White ☐ Asian ☐ Other _____

Emergency Contact: _____ Relation to Client:_____

Phone _____Address _____

Referred by: _____ Agency _____

Phone _____ email: _____

How long has referring person known client and in what capacity: _____

_____

## FILL OUT FOR ALL APPLICANTS

**Please provide as much information as possible about person's situation:**

## FILL OUT FOR ALL APPLICANTS

## Housing Related Issues affecting Health and/or Healthcare

Is this client a frequent utilizer of the Emergency Department , Urgent Care or inpatient care?
☐ Yes ☐ No

If YES, number of Emergency Dept. visits in past 12 months _____ Where?_____

number of inpatient stays in the last 12 months _____Where?_____

Would utilization change if the client had new or stable housing?
☐ Yes ☐ No

If YES, explain why.

Would stabilizing or finding new housing for this client improve his/her health and/or reduce this client's healthcare costs?

☐ Yes ☐ No

If YES, explain why.

Any other comments related to **how housing affects this person's health.**

## FILL OUT IF APPLICANT IS HOMELESS

**Homelessness:**

Homeless ☐ Yes ☐ No If yes, for how long: _____

Chronically Homeless (meaning CURRENTLY homeless for more than 1 year, or 4 or more times in last 3 years—AND DISABLED?) ☐ Yes ☐ No

**Current living situation:**

☐ Shelter (Which one: _____)

☐ Program (Which one:_____)

☐ Streets ☐ With Friends/Family ☐ Other: _____

**Additional Comments related to homelessness:**

## FILL OUT IF APPLICANT IS <u>CURRENTLY HOUSED</u>

**<u>Prevention:</u>**
At risk for losing housing? ☐ Yes ☐ No
***If yes:*** Explain. Provide relevant dates:

Has tenant received Notice to quit?

☐ Yes (Date & Reason_____) ☐ No ☐ Don't know

Has tenant received Summary Process Notice?

☐ Yes (Court Date & Location_____) ☐ No ☐ Don't know

Current Housing type: ☐ project based ☐ voucher ☐ market rate apartment

Length of time lived there: _____ Rent amount: _____

Does landlord say that client owes unpaid rent? ☐ Yes ☐ No Amount: _____
_____

Has a place to go if housing is lost? ☐ Yes ☐ No

**Additional Comments related to current housing situation:**

## FILL OUT FOR ALL APPLICANTS

**Housing History:**

Does client owe any unpaid rent to any landlord (public housing authority or private management company)?

☐ Yes ☐ No If so, please list amount: _____

to whom: _____

from when: _____

Has client ever had subsidized/public housing?

☐ BHA ☐ Section 8 ☐ Other subsidized housing ☐ Not sure ☐ No

If so, when and where? _____

Has client ever been evicted?

☐ Yes ☐ No If so, was it from subsidized/public housing? ☐ Yes ☐ No

Please explain when and why:

Has client ever been to housing court?

☐ Yes ☐ No If so, please explain why and what happened:

**Criminal History:**

Does client have any criminal convictions? ☐ Yes ☐ No

Does client have any open criminal cases or outstanding warrants? ☐ Yes ☐ No

**Documents:**

Please check all the following documents that the client currently has:

☐ Birth Certificate ☐ Massachusetts Photo ID ☐ Social Security Card

Does client receive food stamps? ☐ Yes ☐ No If so, how much: _____

**Note:**

All clients will be asked to provide a list of ALL addresses for the past 3 years, including staying with friends or family, even if not on the lease or paying rent. Include dates when client lived there and landlord's name, if client knows it. Also include stays at homeless shelters and or on the streets. Client will have to provide this at a later date.

Clients will also be asked to provide detailed information about any criminal convictions client has.

**Substance Use:**

**Alcohol**
Does client have **alcohol** addiction/abuse?
☐ Current ☐ Past but now sober (For how long?_____) ☐ Never

**Drugs**
Does client have **opioid or other drug** addiction/abuse?
☐ Current ☐ Past but now clean (For how long?_____) ☐ Never

**Smoking**
Does client smoke cigarettes/cigars? ☐ Yes ☐ No If so, how much?_____

**Supports**

Are there any family members currently providing support of any kind to the client? (Support includes financial, emotional, assistance with daily activities, etc.) ☐ Yes ☐ No

If yes, please explain who they are and what kinds of support they are providing.

Name: Relationship:

Phone: _____ Address _____

What kind of support do they provide? _____

_____

**Medical**

Please describe any medical issues or disabilities that may impact housing need and/or stability.

**Release of Information**
**Elders Living At Home Program**

I, _____ Date of Birth _____
as a client or potential client of the Elders Living At Home Program and the Medical Legal Partnership|Boston, give permission to all of the below listed people/agencies to disclose to all staff of the Elders Living At Home Program and the Medical Legal Partnership|Boston any and all information about me pertaining to housing, health, nutrition, finances, and medical and mental health care. I understand that the Elders Living at Home Program and the Medical Legal Partnership|Boston will use this information to assess, evaluate and/or assisting me with all issues related to my health, housing and housing stability.

I further give permission to all staff of the Elders Living At Home Program and the Medical Legal Partnership|Boston to release any and all housing, health, nutrition, finances, and medical and mental health care information about me to the below listed people/agencies insofar as it pertains to my health, housing and housing stability.

I understand that once the information is released, the recipient of the information may disclose it to others.

**People/Agencies who may release information to and receive information from the Elders Living At Home Program and the Medical Legal Partnership|Boston:**

- My Primary Care Provider
- All healthcare providers from whom I have received services in the last 12 months
- All mental health providers from whom I have received services in the last 12 months
- All Homeless Shelters where I have stayed in the last 12 months
- All programs (i.e. substance abuse treatment programs, etc.) in which I have been a participant in the last 12 months
- All current & former landlords, rental management companies and public housing authorities
- All utility companies (such as gas, electric, oil, water and telephone)
- Hale Barnard Services and the Bill Payer Program
- Social Security Administration
- Massachusetts Department of Transitional Assistance
- City of Boston's Department of Neighborhood Development
- Attorneys working on my behalf and any opposing attorneys

I understand that a copy of the original form/signature is valid. I understand that this consent is subject to revocation by me, in writing, at any time, unless action based on it has already begun. This authorization expires two (2) years from the date signed.

_____ _____
Signature of Client Date