Harbor Place

COVID-19 Isolation, Quarantine & Recovery Accommodations

Harbor Place
3164 Shelburne Road,
Shelburne VT 05482

Guest Criteria

Isolation, Quarantine & Recovery guests of Harbor Place meet the following criteria:

- ✓ Are symptomatic and suspected of having COVID-19 but do not require hospital care; **or**
- ✓ Have been exposed to COVID-19 and have been assessed as high-risk for being COVID-19+ by a medical provider; **or**
- ✓ Test positive for COVID-19 (confirmed case) with minimal or no symptoms; **and**
- ✓ Require self-isolation due to risk of infecting others during recovery and have no other suitable place to self-isolate; **and**
- ✓ Do not require hospital level of care (may be discharging from a hospital or referred directly from current housing); **and**
- ✓ Do not require assistance with daily living and can self-evacuate the building if needed.

For individuals suspected or at high risk for being COVID-19+, referrals are only accepted from:

- DCF Economic Services Division (ESD) - Emergency Housing Program, **or**
- Community Health Centers of Burlington, **or**
- UVM Medical Center, **or**
- A physician or health center outside Chittenden County.

How to Make a Referral

1. Referring agency will initially assess whether the individual meets the criteria for admission at the site. Guests of COVID-19 isolation, quarantine, and recovery housing meet the criteria listed above.

2. Referring agency will ensure that they have what they need to complete the referral via phone:
    a. Permission from the client to make the referral
    b. Access to the client during the referral conversation (conference call or sitting in the same room at a safe distance) to help answer questions.

3. To initiate a referral, please call Harbor Place Staff at: **802-316-7112.** You will be asked to complete and send the following to the Harbor Place referrals email: **HP-Team@champlainhousingtrust.org**:
    a. A scanned copy of photo ID or, if the guest has no photo ID, a photo of the guest; **and**
    b. Harbor Place Temporary Housing & Billing referral form (Attachment A); **and**
    c. Signed Guest Agreement form (Attachment B); **and**
    d. Champlain Housing Trust HIPAA form (Attachment C); **and**
    e. **If** the individual does not have a primary care provider in the Burlington area and is willing to have the Community Health Centers of Burlington take on that role while they are staying at Harbor Place, please also send the Community Health Centers of Burlington Patient Registration Form (Attachment D); **and**
    f. **If** the individual has tested positive for COVID-19, a confirmation of testing.

4. **Please do not send guests to the site until you have received confirmation of reservation.** Upon receiving all required information/documentation and determining that the individual is accepted at the

site, Harbor Place staff will confirm the reservation, ensure that the guest and Harbor Place staff are both prepared for arrival. All guests must arrive after 10 a.m. and before 8 p.m. on weekdays and after 11 a.m. and before 7:00 pm. on weekends.

5. Clinical Staff with the Community Health Centers of Burlington will work to arrange telehealth care for individuals if they are not arranging their own care.

6. Guests' PCPs and Community Health Centers of Burlington staff will participate in the discharge process to provide final authorization that staff can discharge guests.

Referral Checklist – Information to Have Available

During the referral process, the referring agency will be asked to provide the following information (as available) from the potential guest to support staff in assessing appropriate placement.

- ☐ Guest Name
- ☐ Date of Birth
- ☐ Do you have an existing Release of Information with the Champlain Housing Trust and Community Health Centers of Burlington, or can you complete one now? (Verbal and/or written)
- ☐ Are they on Medication Assisted Therapy? (this is not a barrier, just important)
- ☐ Living situation – what is the reason why they do not have a place to self-isolate? Where will they return to when they recover?
- ☐ Date of test – place and verification of positive result
- ☐ Date of onset of symptoms, if known
- ☐ Current symptoms
- ☐ Ability to care for self – for example ambulating, doing personal laundry, driving, taking medications, managing any chronic conditions
- ☐ Supply of medications – will they have at least 14 days with them when they arrive? If not, who orders their prescription?
- ☐ Are there any safety plans in place that we need to be aware of?

Please do not send guests to the site until you have received confirmation of placement from Harbor Place.

Attachment A

Harbor Place Temporary Housing Reservation and Billing Form

To be completed by agency and emailed to: HPManager@champlainhousingtrust.org; mohler@champlainhousingtrust.org; and etaylor@champlainhousingtrust.org

Referring Agency: _____

Head of Household Name (HH): _____

HH Date of Birth: _____ HH Phone Number: _____

Number of Adults in household: _____ Number of Children: _____

Ages of Children: _____

Service Animal? ___ Yes ___ No

Check In Date: _____ Check Out Date: _____

Staff person Authorizing Stay:

Case Management Services to be provided by: _____

Case Manager's Phone: _____

Case Manager's Email: _____

Payment Method:

___ Client Self Pay (agency check, cash, money order, credit card)

___ Bill to Agency

Have you called to confirm room availability? If not, please call Harbor Place at 802-316-7112.

To be completed by Champlain Housing Trust and returned to staff person authorizing stay.

For guests above:

Check In Date: _____ Check Out Date: _____

Reason for check out:

___ End of authorized stay

___ Violation of guest rules

___ Other: _____

Attachment B

Harbor Place Guest Agreement: Your Rights and Responsibilities

To reach the front desk, dial 0 or 985-0058. If no one answers, dial 862-6244. For Emergencies, dial 9-1-1

Criteria
In order to be a guest at Harbor Place you must:

- Be suspected of being positive for COVID-19, be at high-risk, or have tested positive for COVID-19
- Be able to manage your own activities of daily living
- Have no other suitable place to self-quarantine/isolate (to support healthy recovery and prevent infecting others)
- Be able to follow Responsibilities as listed below
- **Choose to be here** (isolating at this site is voluntary) and agree to the rules if you choose to stay.

<u>Your Rights</u>: What you can Expect from Us

We are glad that you are here and you can expect the following from us:

- Supportive staff on site and available by telephone to help ensure your needs and the needs of others are met
- Clean bedroom and bathroom when you arrive, and supplies to keep it clean
- Access to a laundry facility by appointment (call the Front Desk to make an appointment)
- Food delivered to your room daily.
- Security onsite to ensure that it is a safe environment for you and others
- Access to a healthcare provider and to testing
- Personal protective equipment including a face mask, gloves and room cleaning supplies.

<u>Your Responsibilities</u>: What we Expect from You

For your health and safety and the health and safety of others, we ask you to accept the following responsibilities. If you do not act according to these responsibilities, you may be asked to leave:

Health and Wellbeing

- You are responsible for your own health. Please pay attention to how you are feeling and let your medical provider know if you start to feel ill and we will help you get the medical care you need.
- Please maintain personal hygiene.
- Please keep your room clean, and clean up after yourself, using disinfecting supplies to clean surfaces every day.
- Please always wear a face mask and gloves when you are around others.
- Please take care of yourself, rest to support your recovery, and remain safe.
- Please be respectful of others, including other guests, staff, and volunteers.

Staying at the Harbor Place

- While you are staying at Harbor Place, you must remain onsite at all times. Visitors are not permitted except as pre-arranged with the front desk, for deliveries to be dropped off on the porch of the office.

- You may go outside for fresh air onsite on the premises so long as you maintain a distance of at least six feet from others who may be outside. Please wear a mask when outside, to protect the health of others. You are required to stay on the premises, and that is monitored by staff. If you have children with you, they must be supervised at all times while outside.
- Alcoholic beverages may not be consumed outside of rooms.
- Smoking is not permitted in the rooms. You will be asked to leave and may be subject to a $100 charge if there is smoking in your rooms. You may smoke outside with room doors closed and ten feet away from the building.
- In-room local phone service is available.
- Single rooms include a mini-fridge and microwave. Efficiency rooms include a refrigerator and stove. Guests may not use their own cooking devices, including hot plates and electric fry pans, within any room of the premises and may not use any open flame cooking device on the premises, including grounds and decks.
- No pets are allowed. Service animals assisting persons with disabilities are permitted.
- Registered sex offenders are not permitted to stay due to the vulnerability of other guests and will be asked to leave if found to be on the registry.
- If you decide to end your stay at Harbor Place, we can arrange transportation to a reasonable destination within the State. **Once you leave Harbor Place you may not be able to return.**

Behavior

- If you are required to follow certain restrictions or conditions from other programs, you are expected to follow them here.
- If you are found to be selling drugs on the property, we will notify the police, and obtain a no-trespass order.
- Weapons, violence and threatening behavior, including verbal sexual harassment, are not allowed.
- You must be clothed and have shoes or slippers on at all times.
- If you violate these guest rules, you may be asked to leave.

Personal Items

- Please take with you any items that you bring.

By signing below I agree that I have read this agreement and understand <u>my rights</u> (what I can expect from Harbor Place) and <u>my responsibilities</u> (what is expected of me, and that I must follow) that are listed above.

Guest Signature_____ Date_____

Guest Name_____ Date_____

Staff Signature_____ Date_____

Attachment C

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Print Name: _____

I. My Authorization

I authorize Champlain Housing Trust, Inc. to use or disclose the following health information:

☐ - All of my health information

☐ - My health information relating to the following treatment or condition:

COVID-19 _____

☐ - My health information covering the period from _____ (date) to _____ (date)

☐ - Other: _____

The above party may disclose this health information to any healthcare, social service or housing provider providing services to me during my stay at Harbor Place.

The purpose of this authorization is (check all that apply):

☐ - To provide healthcare, social services and/or related services during my stay at Harbor Place and/or to facilitate my ability to obtain other housing.

☐ - Other: _____

This authorization ends:

☐ - On (date)_____

☐ - When the following event occurs: _____

II. My Rights

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that services provided by any party may not be made subject to signing this authorization and that I may have the right to refuse to sign this authorization.

Signature of Patient: _____

Date: _____

Signature of Authorized Representative: _____

Date: _____

III. Additional Consent for Certain Conditions

This medical record may contain information about **physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment**. Separate consent must be given before this information can be released.

☐ - I consent to have the above information released.

☐ - I do not consent to have the above information released.

Signature of Patient or Authorized Representative: _____

Date: _____ Time: _____

IV. Additional Consent for HIV/AIDS

This medical record may contain information concerning **HIV testing and/or AIDS diagnosis or treatment**. Separate consent must be given to have this information released.

☐ - I consent to have the above information released.

☐ - I do not consent to have the above information released.

Signature of Patient or Authorized Representative: _____

Date: _____ Time: _____

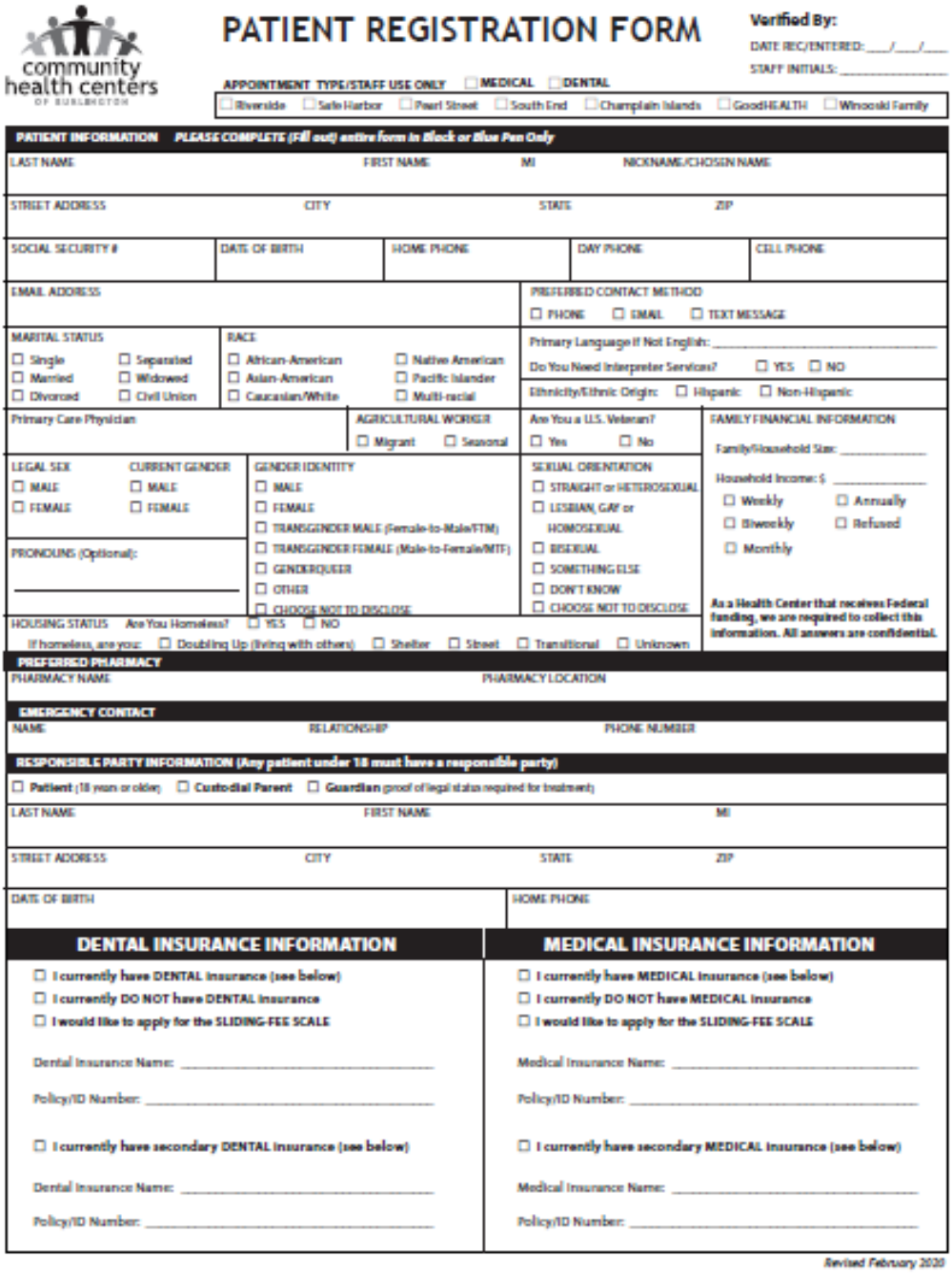
Attachment D

Community Health Centers of Burlington – Patient Registration Form

If the individual (potential guest) does not have a primary care provider in the Burlington area and is willing to have the Community Health Centers of Burlington take on that role while they are staying at Harbor Place, please also send the Community Health Centers of Burlington Patient Registration Form.

[Click on this link to access the Patient Registration Form on the CHCB Website](#).

Print, complete, scan, and send back to HP-Team@champlainhousingtrust.org.



community health centers OF BURLINGTON

PATIENT REGISTRATION FORM

Verified By:
DATE REC/ENTERED: ___/___/___
STAFF INITIALS: _____

APPOINTMENT TYPE/STAFF USE ONLY ☐ MEDICAL ☐ DENTAL
☐ Riverside ☐ Safe Harbor ☐ Pearl Street ☐ South End ☐ Champlain Islands ☐ GoodHEALTH ☐ Winooski Family

PATIENT INFORMATION *PLEASE COMPLETE (Fill out) entire form in Black or Blue Pen Only*

LAST NAME | FIRST NAME | MI | NICKNAME/CHOSEN NAME

STREET ADDRESS | CITY | STATE | ZIP

SOCIAL SECURITY # | DATE OF BIRTH | HOME PHONE | DAY PHONE | CELL PHONE

EMAIL ADDRESS | PREFERRED CONTACT METHOD ☐ PHONE ☐ EMAIL ☐ TEXT MESSAGE

MARITAL STATUS
☐ Single ☐ Separated
☐ Married ☐ Widowed
☐ Divorced ☐ Civil Union

RACE
☐ African-American ☐ Native American
☐ Asian-American ☐ Pacific Islander
☐ Caucasian/White ☐ Multi-racial

Primary Language if Not English: _____
Do You Need Interpreter Services? ☐ YES ☐ NO
Ethnicity/Ethnic Origin: ☐ Hispanic ☐ Non-Hispanic

Primary Care Physician

AGRICULTURAL WORKER ☐ Migrant ☐ Seasonal

Are You a U.S. Veteran? ☐ Yes ☐ No

FAMILY FINANCIAL INFORMATION
Family/Household Size: _____
Household Income: $ _____
☐ Weekly ☐ Annually
☐ Biweekly ☐ Refused
☐ Monthly

LEGAL SEX ☐ MALE ☐ FEMALE
CURRENT GENDER ☐ MALE ☐ FEMALE

GENDER IDENTITY
☐ MALE
☐ FEMALE
☐ TRANSGENDER MALE (Female-to-Male/FTM)
☐ TRANSGENDER FEMALE (Male-to-Female/MTF)
☐ GENDERQUEER
☐ OTHER
☐ CHOOSE NOT TO DISCLOSE

PRONOUNS (Optional): _____

SEXUAL ORIENTATION
☐ STRAIGHT or HETEROSEXUAL
☐ LESBIAN, GAY or HOMOSEXUAL
☐ BISEXUAL
☐ SOMETHING ELSE
☐ DON'T KNOW
☐ CHOOSE NOT TO DISCLOSE

As a Health Center that receives Federal funding, we are required to collect this information. All answers are confidential.

HOUSING STATUS Are You Homeless? ☐ YES ☐ NO
If homeless, are you: ☐ Doubling Up (living with others) ☐ Shelter ☐ Street ☐ Transitional ☐ Unknown

PREFERRED PHARMACY
PHARMACY NAME | PHARMACY LOCATION

EMERGENCY CONTACT
NAME | RELATIONSHIP | PHONE NUMBER

RESPONSIBLE PARTY INFORMATION (Any patient under 18 must have a responsible party)
☐ **Patient** (18 years or older) ☐ **Custodial Parent** ☐ **Guardian** (proof of legal status required for treatment)

LAST NAME | FIRST NAME | MI

STREET ADDRESS | CITY | STATE | ZIP

DATE OF BIRTH | HOME PHONE

DENTAL INSURANCE INFORMATION
☐ I currently have DENTAL insurance (see below)
☐ I currently DO NOT have DENTAL insurance
☐ I would like to apply for the SLIDING-FEE SCALE
Dental Insurance Name: _____
Policy/ID Number: _____
☐ I currently have secondary DENTAL insurance (see below)
Dental Insurance Name: _____
Policy/ID Number: _____

MEDICAL INSURANCE INFORMATION
☐ I currently have MEDICAL insurance (see below)
☐ I currently DO NOT have MEDICAL insurance
☐ I would like to apply for the SLIDING-FEE SCALE
Medical Insurance Name: _____
Policy/ID Number: _____
☐ I currently have secondary MEDICAL insurance (see below)
Medical Insurance Name: _____
Policy/ID Number: _____

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