



ADMISSION CRITERIA and REFERRAL PROCESS

Admission Criteria

- Homeless/becoming homeless/lives in an inappropriate post-hospitalization setting
- Medically and psychiatrically stable at discharge
- Alert and oriented to name, date, location and situation
- Able to independently complete all daily activities
- The patient is able to self-administer medication with staff oversight
- The patient is continent of both bladder and bowels (If incontinence garments are used, the patient must be able to change them independently)
- DME devices may be accepted, provided:
 - The patient has the ability to use them independently and safely, including transfers to toilet and other similar activities
 - A minimum ambulation distance of 100 feet has been reached prior to hospital discharge, with or without DME use.

Exclusion Criteria

- Unable to transfer or perform ADLs
- The cognitively impaired
- Patients with active tuberculosis/C-DIFF/MRSA of sputum
- Meets admission criteria for SNF/LTC
- Stage 3 or higher decubitus ulcers and cardiac EF % <30
- Unwillingness to abstain from active substance abuse
- Combative or aggressive behavior towards staff or other patients
- Patients actively detoxing will need to be stabilized prior to referral

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Referral Process

A referral form with supporting documentation must be emailed or faxed to our Referral Coordinator. Confirmation of receipt will be provided within 2–3 hours. Documents will be reviewed and the hospital will be contacted with questions. The Referral Coordinator will then determine approval or denial of the patient. If approved, the Referral Coordinator will coordinate the patient’s admission. If denied, a reason will be provided.

Additional Details

- Referring hospital must fax a completed discharge checklist and discharge summary, with instructions
- New clients may arrive between 9 a.m. – 6 p.m. daily, 365 days a year
- Referring hospital/facility are responsible for client transportation to Horizon Centers
- Clients must arrive with medications for entire length of stay according to discharge instructions before intake can begin
- If a medical case manager conducting the intake assessment determines that the patient is not suitable for our program, the client will be returned to the hospital within 36 hours, as indicated in the letter of authorization
- A case manager will also provide a social intake within 48 hours of arrival
- The referring hospital must coordinate home health if needed, which must be in place prior to hospital discharge