**Projects for Assistance in Transitioning from Homelessness (PATH) Program**

**Hospital Discharge Referral Procedures**

**Before Referral**

* Screen all admissions for housing need;
* If homeless, in need of housing and already connected to an adult mental health service provider such as ICM, CST, ACT, contact that provider for assistance in reengaging the individual in services and connecting them to temporary/transitional housing via provision of community transition planning (CTP) while the individual is hospitalized.
* After specialty service provider has been contacted and it is determined that housing assistance is still required; specialty service provider is not able to assist with housing placement, then refer to PATH Team,
* If homeless, in need of housing and not connected to an adult mental health service provider, discuss PATH Program with Individual and determine if Individual will allow PATH referral. Individual does not have to agree to enroll in PATH services at that time; PATH Team members are trained to engage individuals and will provide initial on-site outreach services once in receipt of the referral,
* In the event that there are Provider concerns, Hospital Staff should notify appropriate Regional Service Administrator for assistance,

**Referral**

* Upon hospital admission of an individual with verified homeless status, initiate contact with PATH Team,
* PATH referral should be made at least 72 hours prior to expected discharge; in the event that a person with homeless status discharges prior to the PATH referral, send referral and contact information to appropriate PATH team **PATH Teams may not be able to accommodate same day referrals,**
* In Region 3, Call regional field office Transition Coordinator,
* For Regions 1, 2, 4, 5, 6 Call PATH Team Directly (see Provider Directory pp. 48-49) <https://dbhdd.georgia.gov/sites/dbhdd.georgia.gov/files/related_files/site_page/2015%20AMH%20Directory%208.14.15.pdf> ,
* Complete referral paperwork and send to PATH Team per form instructions. For Region 3 referrals, the paperwork should be sent to the Region 3 Field Office,
* PATH Team member will come to hospital to engage Individual and determine Individual’s desire to enroll in PATH services,
* PATH Team Member may request that hospital physician complete HUD McKinney Vento documentation to verify Individual’s eligibility

**After Patient Enrollment in PATH Services**

* If Individual chooses to enroll in PATH services, PATH Team Member will attempt to find appropriate housing placement (e.g., transitional program bed, extended stay hotel, etc.)
  + Housing placement is subject to bed availability, risk factors, and PATH Team financial resources
  + Upon discharge the following documents are required from the hospital:
    - TB test w/date
    - RPR Test w/date
  + Homeless Verification/Shelter Referral Letter
* Schedule appropriate outpatient follow-up appointment and provide all relevant information in writing to PATH Team Member.
* Coordinate with PATH Team to identify plan for safe transportation to housing placement.
* Document disposition information provided by PATH Team member. Hospital SW staff will document via SW Discharge Note and on the SW Discharge Instructions the name of PATH provider and team member, what facility the PATH Team is taking the person to, transportation details, etc. or that the Person met with the PATH Team and refused services.

**Following discharge from the hospital, the goal of the PATH Team is to ensure that the individual successfully connects with behavioral health services in the community and is eventually placed in permanent supported housing, via Shelter + Care, the DCA Housing Choice Voucher, Georgia Housing Voucher, DCA Section 811 Housing, VA Supported Housing (VASH), etc.**