Vancouver Home Support Team
Flexible Adaptable Home Support Team (FAHST)
Robert and Lily Lee Community Health Center
FAHSTReferrals@vch.ca
Phone: 604-875-4111 Ext: 22685

FAHST (Flexible Adaptable Home Support) Referral Form

The FAHST team is a specialized group within Home Support that helps clients with their daily living and care needs. This team is made up of Community Health Workers, Nurses, a Community Liaison Worker, and Schedulers. They collaborate closely with clients and their care providers to create home support plans that are flexible and can adapt to each client's unique needs.

Clients of the FAHST team often face significant challenges in accessing healthcare and may have complex needs. Some clients might be unhoused or struggling to keep their housing, and many have found it difficult to maintain or qualify for traditional home support services.

To be eligible for FAHST Home Support, the client:

- Needs help with daily care tasks, assistance around the home, and support connecting with the community (ADLs and IADLs) to maintain housing, health, and dignity.
- Requires a flexible schedule, with regular reviews and adjustments to the home support care plan to ensure continued service and well-being.
- Needs consistent care from the same staff members.
- May be unhoused or living in unstable housing—while this is not required for eligibility, these clients will be prioritized.
- Has either been unable to access or struggled to benefit from traditional home support services for various reasons.

Priority Criteria (Clients with the following situations will be given priority):

- Currently unhoused or at risk of losing housing because they cannot complete personal care or IADL tasks on their own.
- Frequent hospitalizations in the past 6 months.
- Recent difficulties in accessing traditional home support, such as refusing services, staff unable to regularly contact the client, or not meeting the usual criteria for Home Support.
- Few or no supportive relationships, including friends, family, or formal support systems.

Exclusion Criteria:

- Lives far from other current FAHST clients.
- When client presents as a danger to staff.

Please note:

- The referral review process may take up to 2 weeks; we are unable to accommodate urgent requests.
- Part of our review process includes a visit to the client by our team, in collaboration with the referral source and any other relevant parties supporting the client.

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FAHST Team Referral Form

This form should be completed by the individual most familiar with the client. We may reach out to you for additional information if needed.					
Client Participation:					
Clients referred to the FAHST Team must consent to participate in the program.					
Has client consented to FAHST services?	☐ YES ☐ NO				
Referral Source:					
Name and Title:					
Referral Team:					
Phone Number:		Email:			
Connection to Client:					
Client Information:					
Date:		PHN:		PARIS ID:	
Client Name:		Preferred Name:			
Gender Identity (woman, man, non-binary, etc.):		Pronouns (she/her, he/him, they/them, etc.):			
Client Address:		Access / Entry:			
Client Phone Number:		Client Email:			
Building Manager Name:		Contact Number / Email:			
Emergency Contact Name:		Contact Number / Email:			
Client Support Needs:					
Personal Care: Assistance with dressing, mouth care, hair washing, bathing, peri-care, bowel/bladder management, eating/feeding, meal preparation, transferring, and medication management. **Instrumental Activities of Daily Living (IADLs):** Support with tasks such as laundry, food preparation, and light housekeeping. **Community Integration:** Assistance with attending appointments, connecting with community resources, paying bills, shopping for food, and other activities essential for maintaining housing and independence.					
Please list the specific tasks the client requires assistance with and the approximate frequency. Example: Bathing and laundry once per week, medication assistance once per day.					
Experience with Home Support:					
Is the client currently receiving Home Support services, or have they received them in the past?	☐ YES ☐ NO ☐ UNSURE	If yes, when? What challenges did they face?			

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Client's Health and Social History			
Physical:			
Relevant medical conditions and/or physical disabilities	Describe:		
Mental Health:			
Relevant mental health diagnosis and/or conditions	Describe:		
Signs of Decompensation: What does it look like when this person becomes unwell?	Describe:		
Substance Use:			
Does applicant have a history of substance use?	☐ YES ☐ NO ☐ UNSURE	If yes, are they currently using?	☐ YES ☐ NO
Please describe (i.e., - substance(s) of choice (including tobacco and alcohol), - frequency of use, - mode of ingestion:			
Violence / Aggression (e.g., Verbal, or physical aggression):			
Any concerns that could cause a risk to Home Support Staff?	☐ YES ☐ NO		
If yes, please provide details (please include description, triggers, frequency of incidents):			
Are there any other risks in the home that we should be aware of? (Weapons, pets, pests, etc.).	☐ YES ☐ NO If YES, please describe:		
Behavioural Care Plan (BCP) in Place (If accepted by FAHST, a BCP will be required):	☐ YES ☐ NO		
List Other Healthcare Connections or Services Client is Receiving (if known):			
☐ Family Doctor Or ☐ Walk – In Clinic:		☐ Psychiatrist:	
☐ Mental Health Team:		☐ Counsellor:	
☐ Addictions Team:		☐ Home Support:	
☐ Primary Care:		☐ Other:	
Please provide any other relevant details:			

Please email completed referrals to FAHSTReferrals@vch.ca. For questions call (604)875-4111 ext.22685.