



# Emergency Shelter Operational Plan

**BICS Vendor Code (for counties outside of NYC):**

**Submission Date:**

**Type of Plan Submission:**      Initial Certification      Re-Certification      Plan Amendment

## Section 1 - General Information

**Existing Shelter**      **New Shelter**

### Facility Information

**Facility Name:** \_\_\_\_\_ **a.k.a.** \_\_\_\_\_

**Address:**

**City:** \_\_\_\_\_ **State:** NY **Zip:** \_\_\_\_\_ **County:** \_\_\_\_\_

**Borough:** (If Applicable) \_\_\_\_\_ **Community District:** (If Applicable) \_\_\_\_\_

**Number of proposed Beds:** \_\_\_\_\_ **Number of Individuals currently in Residence:** \_\_\_\_\_

**Adult Shelter**      **Adult Family Shelter**      **Mixed Adult/Adult Family Shelter\***

\*Submit separate 18 NYCRR Part 900 & 18 NYCRR Part 491 operational plans if certification is being sought for a facility serving a mixed population for both Families and Adults.

**Standard Shelter**      **Cluster Site (NYC)**      **Emergency Housing Apartments - EHAP (ROS)**

### Operational Plan Primary Contact Person:

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Individual(s) designated to be a contact person at this facility:**

**Name:** \_\_\_\_\_ **Title:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Email:** \_\_\_\_\_

### Specialties (check all that apply)

- |                               |                          |                          |
|-------------------------------|--------------------------|--------------------------|
| <b>Congregate</b>             | <b>Pregnant women</b>    | <b>Employment</b>        |
| <b>Private Units</b>          | <b>Veterans</b>          | <b>Education/GED/ESL</b> |
| <b>Reception / Assessment</b> | <b>Domestic Violence</b> | <b>Substance Abuse</b>   |
| <b>Overnight Respite</b>      | <b>Ex-offenders</b>      | <b>Mental Health</b>     |
| <b>Other</b>                  |                          |                          |

### District Information

**Local Department of Social Services (LDSS):**

**Name of LDSS Contact:**

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_ **Email:** \_\_\_\_\_

### Program Operator Information (if other than LDSS)

**Name of Program Operator/Organization:**

**Address:**

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Tax Exempt Number:**

**Date Approved:**

**Provider Responsibilities:** (e.g. facility operations only, casework, minor repairs, trash/snow removal, etc)

**Individual(s) designated to be a contact person at the sponsoring organization:**

**Name: Title: Phone: Email:**

**Other program(s) currently or previously operated by sponsor at this facility:**

**Program Operator Board of Directors** (you may attach a BOD profile in lieu of the following)

**Member's Name:**

**Position: President/Chair Term of Office: Occupation:**

**Phone: Fax: Email:**

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**Member's Name:**

**Position: Vice President/Chair Term of Office: Occupation:**

**Phone: Fax: Email:**

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**Member's Name:**

**Position: Treasurer Term of Office: Occupation:**

**Phone: Fax: Email:**

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**Member's Name:**

**Position: Secretary Term of Office: Occupation:**

**Phone: Fax: Email:**

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**Member's Name:**

**Position: Term of Office: Occupation:**

**Phone: Fax: Email:**

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**Member's Name:**

**Position: Term of Office: Occupation:**

**Phone: Fax: Email:**

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**Member's Name:**

**Position: Term of Office: Occupation:**

**Phone: Fax: Email:**

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**Member's Name:**

**Position: Term of Office: Occupation:**

**Phone: Fax: Email:**

## Physical Plant Management

Name of Property Management Organization (if any):

Address:

City: State: Zip:

Phone: Fax: Email:

Tax Exempt Number:

Provider Responsibilities: (e.g. facility operations only, maintenance)

Individual(s) designated to be a physical plant contact person at the sponsoring organization:

Name: Title: Phone: Email:

Name of individual(s) designated to be a physical plant contact person at this facility:

Name: Title: Phone: Email:

Other program(s) currently or previously operated by sponsor at this facility:

## Physical Plant and Land Owner Information

Name of Property Owner or Organization:

Address:

City: State: Zip:

Phone: Fax: Email:

Total years owned facility: Date Lease Expires:

If facility is leased, state the material terms of the lease:

Land Owner's Name (if different):

Address:

City: State: Zip:

Phone: Fax: Email:

Total years owned land: Date Lease Expires:

If land is leased, state the material terms of the lease:

## Building Services

Along with the operational plan, please include copies of all:

- contracts for services provided in the building (trash removal, snow removal, security, etc.);
- copies of leases for the physical plant and/or land.

## **Section 2 Programmatic Services**

### **Community Profile**

**Describe the facility's specific location including cross streets.**

**Identify the nearest available means of public transportation and their distance to the facility.**

**Identify local restaurants and stores that can be easily accessed by the residents.**

**Identify local parks or recreation areas that are easily accessible to the residents.**

**Identify local community services resources including, medical, mental, health or employment centers, etc. that will be/are available to community residents.**

### **Admission and Assessment**

**Describe how clients are referred to the facility by the local social service district.**

**How are referrals for clients who are not appropriate to be housed at the facility handled?**

**During what hours are referrals accepted and are they accepted on weekends and holidays?**

**Describe any restrictions on age, family size or composition and explain why these restrictions are necessary.**

**Describe the facility's admission and intake policies and procedures including timeframes.**

### **Income and Public Benefits**

**Describe the procedures for assisting residents in applying for public benefits, including the provision of transportation.**

## **Resident Rules, Obligations and Rights**

**Describe the procedure for informing residents about facility rules and their obligations and for providing residents with a copy of such rules and obligations upon admission to the facility.**

**Describe the procedure for informing residents about their rights and for providing residents with a copy of such rights upon admission to the facility**

**Identify the locations where resident rights and facility rules/obligations will be posted to be easily accessible to residents and visitors.**

## **Resident Grievances**

**Describe the procedure for receiving and documenting resident grievances or complaints.**

**Describe the safeguards in place for residents to submit grievances anonymously or on behalf of another resident without fear of reprisal.**

## **Resident Funds and Valuables**      **Not applicable**

**Does the provider maintain personal fund or savings accounts for the residents?      Yes      No**  
**If yes, how are the funds secured?**

**If yes, how does the provider ensure that funds are not comingled with facility operating funds?**

**If yes, what type of recordkeeping system is in place to ensure accuracy of the funds?**

**If yes, what is the provider's policy for unclaimed funds should a resident AWOL or be involuntarily discharged from the facility?**

**Does the facility provide storage of personal property including valuables belonging to the resident?      Yes      No**  
**If yes, how are the belongings secured?**

**If yes, how does the provider ensure that belongings are not comingled with facility property?**

**If yes, what type of inventory system is in place to ensure accuracy of the property stored?**

**If yes, what is the provider's policy for unclaimed property should a resident AWOL or be involuntarily discharged from the facility?**

**What hours of access will the resident have to their personal funds or property?**

### **Access by Legal Representative and Counsel**

**Describe the policies/arrangements for providing residents with onsite access to their legal representative or counsel?**

### **Independent Living Plan**

**Describe the activities, including the staff involved, for preparing families for independent living.**

**How often are Service Plans/Independent Living Plans reviewed and revised?**

**Describe how case records will be maintained including documentation for the provision of direct resident services and service referrals.**

**Describe the process for meeting with the resident to set or review individual goals for the Independent Living Plan.**

### **Health Services**

**Describe how the provider will ensure access and referrals to health services for all residents.**

**Is there an established relationship with a fully accredited medical institution or clinic for referral of medical emergencies?**

**Describe the system for maintaining and securing an individual or family's health information and records.**

**Describe all arrangements for the securing of all medications including narcotics and those requiring refrigeration.**

**Describe all arrangements and transportation for medical services or referrals.**

### **Preparation for Permanent Housing**

**Describe the activities and programs aimed at assisting shelter residents with finding permanent housing.**

**Describe any tenancy preparation services provided by the provider to prepare residents for permanent housing?**

**Describe any services designed to train residents, secure jobs or upgrade employment.**

**Describe how the facility staff works with the social service district employment staff.**

**Describe any aftercare services that might be provided.**

### **Provision of Support Services**

**Describe the facilities procedures for providing residents with services, including but not limited to the areas set forth below.**

**Supportive social and mental health services**

**Substance abuse services**

**Employment assessments, services and job training programs**

**Individual and group activities to improve physical and psychosocial functioning**

**Provisions for case management and counseling**

**Transportation between the shelter and any other site used by the social service district or provider for intake or admission**

**Does the provider submit claims to Medicaid and/or any other health insurance company in order to receive payment for services provided?      Yes      No**  
If yes, please explain.

**Information and Referral Services**

**Provide a short description of local community agencies to which residents will be referred by your facility when needed.**

**Describe your facility's procedure for ensuring resident's access to these community agencies/resources.**

**Involuntary Transfer and Discharge**

**Describe the procedure for advising residents of the conduct for which temporary housing may be discontinued.**

**Describe the procedure for notifying the local social service district of acts which may be grounds for the discontinuation of temporary housing assistance.**

**Describe the type of behaviors that will be considered grounds for involuntary transfer or discharge.**

**Describe the local social services district's criteria that will be used to trigger the involuntary transfer or discharge procedure.**

**Describe the procedures detailing the providers responsibilities in relation to the district's requirements for discontinuing temporary housing assistance.**



**Describe the local social service district's procedure for conducting pre-discharge hearings requested by a resident.**

**Describe the local social service district's procedure for informing residents of the decision to the pre-discharge hearing.**

**Describe the local social service district's procedure for informing residents that temporary housing assistance may be discontinued.**

**Describe the procedure of informing residents of their right to request a State Fair Hearing.**

**Describe the local social service district's procedure for discharge.**

### **Voluntary Transfer**

**Describe the local social service district's procedure to determine if a resident has a medical, physical or other special need which cannot be adequately served.**

**Describe how the facility will document resident requests for transfer to another temporary housing placement.**

**Describe the local social service district's procedure of evaluating requests for transfer.**

### **Food Service/Provision of Food**

**Who will responsible for meal preparation for/at the facility?**

**If residents cook, what access do they have to refrigeration and cooking appliances?**

**If staff cook or meals are vender contracted, how will the provider ensure that healthy well-balanced meals are served daily?**

**If staff cook or meals are vender contracted, how will the provider ensure that religious or medical dietary restrictions are met?**

**If staff cook or meals are vender contracted, approximately how many meals will be served daily?**

**If staff cook, how will the provider ensure proper handling and food storage?**

**If meals are contracted, how will the provider ensure that the meals are stored and served at the proper temperature?**

**If congregate dining is utilized, what are the scheduled meal times?**

**If congregate dining is utilized, can the facility accommodate all residents at one seating?**

**If no, how will the facility accommodate seating for meals?**

**Does the facility maintain an emergency food supply?      Yes      No**

**Are there stores and restaurants in the area where residents can utilize their SNAP benefits or restaurant allowance?**

### **General Program Supervision**

**Describe the visit policy, hours/days and areas of the facility available for visitors**

**Describe any restrictions placed on resident's access to the facility and how restrictions vary by time of day.**

### **Other Shelter Programs**

**Are there any other programs operating in the same building? If yes, please explain.**

**If yes, is the program licensed, permitted and/or certified? If yes, by what agency?**

## Facility Staffing and Volunteers

Describe the orientation new staff and volunteers will receive for all emergency procedures including fire drills and evacuations.

Describe the orientation new staff and volunteers will receive for training for surveillance of the grounds, facility and resident activities.

Describe the orientation new staff and volunteers will receive on identifying emergency medical, physical or mental health needs.

How will the provider ensure that at least one staff per shift always has First Aid training?

Will the operator have any staff trained in the administration of naloxone?

Describe the orientation new staff and volunteers will receive for documenting and reporting serious incidents to OTDA.

## Required Document List – Programmatic

Please attach copies of all Documents listed below that are applicable for this application.

1. Lease/Deed or Mortgage
2. Certificate of Incorporation
3. Immediate Needs Intake form
4. Comprehensive Assessment form
5. Facility Rules and Obligations
6. Facility Leave and Absentee policy
7. Resident Rights
8. Facility Grievance/Complaint form
9. Independent Living Plan (ILP)/Service Plan
10. Bi-weekly ILP review form
11. Preliminary Health Screen
12. Memorandum of Understanding or linkages with health and service providers
13. Licenses for any other certified programs housed on-site with the shelter
14. Housing service forms
15. Client referral form
16. Food Handling Certificate
17. Past 2 weeks menus
18. Contracts and selection menus for food provision arrangements for meals prepared off-site
19. Pre-discharge hearings, involuntary transfers or discharge forms
20. Voluntary discharge or transfer forms
21. Daily Census form
22. Daily Admission form
23. Daily Discharge form
24. Sign-in/Sign-out form
25. Staff schedule to include staff's first and last name, title and date of hire
26. Job duties and qualifications for all budgeted staffing positions
27. Facility administrator's resume and qualifications
28. Written statement of duties, responsibilities and tasks that will be delegated to facility staff
29. List of all staff and volunteer trainings for orientation and on-going or annual updates
30. First Aid certificates for all staff, volunteers and security staff utilized to supervise the facility
31. Any or policies, procedures or forms relevant to the operation of the shelter

### Section 3 – Physical Environment

Total number of buildings including administrative buildings.

If more than 1 building is utilized, does each building have a different address?      Yes      No  
If yes, what are the addresses?

Type of building construction for each building. (wood, brick, concrete, etc.)

Total # of units in each building?

What floors/wings will be used for homeless families?

Describe any unique building features and material equipment located therein.

What, if any, renovations or capital projects have recently been completed or are being planned?

Is this building currently receiving HHAP or Shelter Grant funding?      Yes      No

Describe any conditions which must be addressed to ensure resident safety.

If any system or area is not functioning or have been taken offline, please explain.

Describe the land upon which the facility is located.

Are there laundry facilities on site for he residents to utilize?      Yes      No

If no, how will this service be provided?

Does this facility have a commercial kitchen?      Yes      No

Has a lead or asbestos abatement been completed at this facility?      Yes      No      If yes, when?

Does the social service district increase capacity at this facility during snow emergencies and inclement weather?      Yes      No

If yes, how does the provider plan to ensure adequate space, services and safety for the increased capacity?

### Building Code Compliance

Does the facility currently have any building code violations that the provider is aware of?

## Fire Safety Compliance- check all that apply

### Annunciator Panel/Fire Alarm System

		Yes	No
Local	Supervised		
		Sprinkler Smoke Detectors Carbon Monoxide Pull Stations Fire Dampers	

### Monitored Fire Alarm System

		Yes	No
Name of Company:			
Address of Company:			
Date of last inspection:			

### Sprinkler System

		Yes	No
Complete	Wet		
Partial	Dry		
	Combination		
		Units/Dorms Offices Corridors Stairwells Basements Common Areas	

### Monitored Sprinkler System

		Yes	No
Name of Company:			
Address of Company:			
Date of last inspection:			

### Smoke Detectors

		Yes	No
Hard Wired			
Battery Operated			
Supervised			
		Units/Dorms Offices Corridors Stairwells Basements Common Areas	

### Carbon Monoxide Detectors

		Yes	No
Hard Wired			
Battery Operated			
Supervised			
		Units/Dorms Offices Corridors Stairwells Basements Common Areas	

### Fire Extinguishers

		Yes	No
Type:	A B C		
Quantity:			
		Units/Dorms Offices Corridors Stairwells Basements Common Areas	

### Interior Fire Alarm/Pull Boxes

		Yes	No
Local			
Supervised			
		Units/Dorms Offices Corridors Stairwells Basements Common Areas	

### Emergency Lighting

		Yes	No
Hard Wired			
Battery Operated			
		Units/Dorms Offices Corridors Stairwells Basements Common Areas	

### Exit Signage

		Yes	No
Hard Wired			
Battery Operated			
		Units/Dorms Offices Corridors Stairwells Basements Common Areas	

### Evacuation Plans

		Yes	No
		Units/Dorms Offices Corridors Stairwells Basements Common Areas	

### Strobe Lights

		Yes	No
Hard Wired			
Battery Operated			
		Units/Dorms Offices Corridors Stairwells Basements Common Areas	

### Voice Communication (Fire & Safety)

		Yes	No
Fire Panel	Walkie Talkies		
Hallway Speakers	Cell Phones		
Intercom	Other:		
Bullhorn			

### Other Fire Safety Devices

		Yes	No
Fire Suppression System in Kitchen	Self-Closing Fire Doors		
Fire Escapes	Panic Hardware on Exit Doors		
Sandpipe System	Other:		
Interior enclosed stairwells			
Fire Doors			



## Space Analysis

The capacity of a shelter is limited to the capacity approved by the department at the time of certification, or subsequently at the request of the operator. Approvals of capacity will be based upon the department's determination of whether the shelter can operate at the requested capacity in compliance with department regulations and applicable local codes concerning, but not limited to: the physical plant; environmental standards; the proposed program of services and staffing ratios within the shelter.

**Sleeping Areas**      Large Congregate Dorms      Small Bedrooms w/multiple beds in them

# of Dorms or bedrooms      # of individual beds

Handicap Accessible      Yes      No      # of handicap accessible sleeping areas:

Is there adequate sleeping space?      Yes      No

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**Communal Bathrooms**      # of Communal Bathrooms      # of Staff Bathrooms

# of Toilets      # of Sinks      # of Showers      # of Bathtubs

ADL Compliant:      # of Toilets      # of Sinks      # of Showers      # of Bathtubs

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**Communal Kitchens**      Commercial Kitchen      Residential Kitchen

# of Refrigerators      # of Freezers      # of Stoves      # of Microwaves

Fire Suppression System      Yes      No      Date last professionally cleaned:

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### Communal Dining Areas

Is there adequate space per person?      Yes      No      # of Tables      # of Chairs

12-sq feet per person up to 50 people | 10-sq feet per person for 50+ people

Can all residents eat at the same time?      Yes      No      If no, how many can eat at one time?

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### Recreation

# of Recreation areas      Does it share space with any other services?      Yes      No

If yes, please describe the area and the other services that share that area (e.g. dining, classroom, etc.).

## Fire Safety Measures and Security/Disaster Plan

Please attach the facility's plan to provide security and the emergency and disaster plan for the facility and to ensure the physical safety of residents and staff in accordance with 18 NYCRR § 352.38. This plan should be submitted in the OTDA provided format and attached to the operational plan.

Please describe the facility's procedures for handling and documenting incidents that impact the safety and well-being of residents or that impact the safe operation of the facility. At a minimum, the manner of handling the following potential situations should be addressed:

**Actions to be taken if a resident is found to have a mental or physical condition that makes placement inappropriate or causes danger to him / herself or others;**

**Actions to be taken if a resident's behavior is likely to interfere with the health, safety, welfare or care of other residents.**

Actions to be taken if a resident is in need of a level of medical, mental health, nursing care or other assistance that cannot reasonably be provided by the facility or with the assistance of other community resources;

Actions to be taken if a resident has a generalized systemic communicable disease or a readily communicable local infection which cannot be properly isolated and quarantined in the facility;

Actions to be taken if a resident is deemed inappropriate and must be referred to appropriate medical services, child welfare agency, adult protective or law enforcement agency or similar entity;

Actions to be taken if there is an environmental or physical plant issue that can cause immediate harm to residents of the building;

Actions to be taken if an emergency shelter employee is accused of inappropriate behavior;

Describe the facility's process for notification of incidents to the social services districts, OTDA and other relevant officials when necessary as per regulation 18 NYCRR § 352.38(c).

## Required Document List – Environmental

Please attach copies of all Documents listed below that are applicable for this application.

1. Food Service Permit
2. Maintenance Contracts
3. Pest Control Contracts
4. Snow removal Contracts
5. Garbage Removal Contracts
6. Certificate of Occupancy/Letter of Use
7. DOB Elevator Installation Approval (New installations only)
8. Fire Alarm System Inspection
9. Sprinkler System Inspection
10. Fire Suppression System Inspection
11. Evidence of compliance with NYS Sanitary Code Part 14 (commercial kitchens)
12. Fire Extinguisher Inspection
13. New Fire Escape installation approvals
14. Fire Escape Inspection
15. Licenses, permits and certifications for security or fire brigade staff
16. Elevator Inspection
17. Generator Inspection
18. Compactor/Incinerator Inspection
19. HVAC System Servicing
20. Boiler Inspection
21. Residential Furnace Servicing
22. Backflow Prevention Inspection
23. Water Treatment Permit
24. Detailed Floor Plans or Architectural Drawings
25. Safety and Security Plan
26. Evacuation Floor Plans
27. Disaster and Evacuation Plan
28. Any other plans, contracts or inspections for systems associated to the safety and security of this facility

## Section 4 – Waivers

Upon written request by the operator, the department may waive non-statutory requirements of 18 NYCRR 491 of this Title and permit an operator to establish another method of achieving the intended outcome of the waived regulation.

Does the provider or local district have any non-statutory requirements that they would like to request a waiver for?

Yes    No    If yes, attach a Waiver Form for **each** non-statutory requirement.



## Section 5 – Financial Information

The operational plan for each shelter must include on forms and in the manner prescribed by the office a financial statement for the facility's most recently completed fiscal year, if any. In addition, the operational plan must contain a proposed one-year budget, including estimated income and expenditures. Such budget must set forth the costs reasonable and necessary to operate and maintain the facility consistent with each of the requirements of the operational plan and this Part.

- Submit the budget for this facility on the Line Item Budget (Excel Format) that was supplied with this operational plan. OTDA will not accept a budget in any other format.
- Submit a copy of the facility's most recent fiscal audit or certified public accountant prepared financial statement or report.

### Provider:

*I hereby certify that the above operational plan was prepared under my direction and that to the best of my knowledge and belief, the information set forth in this operational plan and all accompanying documentation are true and correct.*

Name:

Title:

Date:

### Local District:

*I hereby certify that the above operational plan was reviewed by this social service department and that to the best of our knowledge and belief, the information set forth in this operational plan and all accompanying documentation are true and correct.*

DSS Reviewer:

Title:

Date: