

Nassau County

Department of Social Services

60 CHARLES LINDBERGH BLVD

UNIONDALE, New York 11553-3686

**NASSAU COUNTY DSS FACILITY HOMELESS REFERRAL FORM**

**Date** Click here to enter a date. **Medical Facility Name** Click here to enter text.

**Name and contact # of Referral Source** Click here to enter text.

**PATIENT NAME** Click here to enter text. **DOB** Click here to enter a date.

**SS#\*** Click here to enter text. **MA/TA CIN, if active in any county** Click here to enter text.

**Patient’s contact# where he/she can be reached** Click here to enter text.

**Does patient have legal status in the United States?**  **Yes**  **No**

**If patient has a case manager, please indicate case manager’s name, agency, contact #:**

Click here to enter text.

**ADMISSION DATE\*** Click here to enter a date. **PROPOSED DISCHARGE DATE\*** Click here to enter a date.

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***ADDRESS PRIOR TO ADMISSION*\*** Click here to enter text.

**Can patient return to this address? If not, explain**\* Click here to enter text.

**Does patient have any friends/relatives he or she can stay with?**  **Yes**  **No**

***(If referring patient for temporary housing placement, potential housing resources in the form of friends, family, neighbors must be explored even if only available on a temporary basis.)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***INCOME/MONTHLY BENEFITS* (Indicate source and amount)\*** Click here to enter text.

**Last date income/monthly benefit was received \*** Click here to enter text.

**How much does patient have available (cash on hand/bank accounts)?\*** Click here to enter text.

**(*Patients referred must meet NYS Temporary Assistance eligibility requirements*)**

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**DOES PATIENT NEED FIRST FLOOR SHELTER PLACEMENT, WOUND CARE OR A REFRIGERATOR FOR MEDICATIONS? (specify)** Click here to enter text.

**DOES PATIENT REQUIRE SKILLED NURSING OR AIDE SERVICES TO RESIDE SAFELY IN THE COMMUNITY?** Click here to enter text. ***(If so, please explore a higher level of care such as a rehab, SNF or Assisted Living residence to meet the patient’s needs.)***

**DOES PATIENT HAVE AN ACTIVE SUBSTANCE ABUSE/ALCOHOL AND/OR MENTAL HEALTH CONDITION? (specify)** Click here to enter text. ***(If yes, is patient prescribed medication or in an out-patient treatment program for condition?)*  Y  N**

**HAS THE PATIENT BEEN ASSESSED AND CLEARED FOR SHELTER PLACEMENT?  Y  N**

**HAS PATIENT BEEN PRESCRIBED MEDICATION FOR A SERIOUS CONDITION/ILLNESS?**

**Yes  No *(If so, please ensure they have been discharged with necessary medication and/or prescriptions. Please note if medication requires refrigeration.)*** Click here to enter text.

**WHAT IS THE FOLLOW-UP TREATMENT PLAN FOR THE PATIENT?** Click here to enter text.

**Is patient a veteran? Yes  No**

**COVID-19 SCREENING QUESTIONS**

***IN THE PAST 14 DAYS:***

1. **Has the patient tested positive for Covid-19? Yes  No**
2. **Has the patient experienced symptoms of Covid-19 that he/she cannot attribute to another health condition? (See the list of potential symptoms below)** **Yes  No**

* *Fever or chills*
* *Cough*
* *Shortness of breath or difficulty breathing*
* *Fatigue*
* *Muscle or body aches*
* *Headache*
* *New loss of taste or smell*
* *Sore throat*
* *Congestion or runny nose*
* *Nausea or vomiting*
* *Diarrhea*

1. **Has the patient been in close contact (within 6 feet) for more than 10 minutes with anyone who has tested positive or has had symptoms of COVID-19 within the last 14 days? Yes  No**
2. **Has the patient spent longer than a 24-hour period in a state that is, or was before he/she left the state, subject to quarantine restrictions on travelers arriving in New York State? Yes  No**

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**E-MAIL REFERRAL TO:**

[HomelessHospDischarge@hhsnassaucountyny.us](mailto:HomelessHospDischarge@hhsnassaucountyny.us)

**Or fax referral to:**

(516) 227-8744

Attn: Hospital Discharge Unit