



NASSAU COUNTY
DEPARTMENT OF SOCIAL SERVICES
60 CHARLES LINDBERGH BLVD., SUITE 160
UNIONDALE, NEW YORK 11553-3686

NASSAU COUNTY DSS FACILITY HOMELESS REFERRAL FORM

Date _____ Medical Facility Name _____

Name and contact # of Referral Source _____

PATIENT NAME _____ DOB _____

SS# IF KNOWN _____

MA/TA CIN IF ACTIVE in any county _____

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

If patient has a case manager what is the case manager's name, agency, contact # if known:

Admission date _____ Proposed discharge date _____

ADDRESS PRIOR TO ADMISSION* _____

Can patient return to this address? If not, explain _____

(If not Nassau County, does patient wish to return to county of last residence? If so, please refer to the local DSS for that county. See <http://ocfs.ny.gov/main/localdss.asp> for contact information). * 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/RESOURCES* (Indicate source, amount and if verified and available) Patients referred must meet NYS Temporary Assistance eligibility requirements.

Indicate if the client has any physical limitations (please indicate if patient requires first floor placement due to limitations): _____

DOES PATIENT REQUIRE SKILLED NURSING OR AIDE SERVICES TO RESIDE SAFELY IN THE COMMUNITY? _____ (If so, please explore if placement in a rehab, SNF or Assisted Living residence would better meet the patient's needs.)

Complete Reverse Side of Referral Form

DOES PATIENT HAVE AN ACTIVE SUBSTANCE ABUSE/ALCOHOL AND/OR MENTAL HEALTH CONDITION? (specify) _____ (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.)

What is the follow-up treatment plan for the patient?

Is patient a veteran? ☐ Yes ☐ No

E-MAIL REFERRAL TO:

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