

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# IF KNOWN** Click here to enter text.

**MA/TA CIN IF ACTIVE in any county** Click here to enter text.

**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:**

Click here to enter text.

**Admission date** Click here to enter a date. **Proposed discharge date** Click here to enter a date.

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

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

**(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.**

Click here to enter text.

**Indicate if the client has any physical limitations (please indicate if patient requires first floor placement due to limitations):** 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 if placement in a rehab, SNF or Assisted Living residence would better meet the patient’s needs.)**

**Complete Reverse Side of Referral Form**

**36N46 (12-16) NC DSS FACILITY HOMELESS REFERRAL FORM**

**-2-**

**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**

**E-MAIL REFERRAL TO:**

HomelessHospDischarge@hhsnassaucountyny.us