EDWARD P. MANGANO
COUNTY EXECUTIVE

JOHN E. IMHOF, PhD
COMMISSIONER


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**

**IF EXHIBITING SIGNS OF MH Dx, HAVE THEY BEEN ASSESSED AND CLEARED FOR PLACEMENT IN A SHELTER? ☐ 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.)**

**Is patient a veteran? ☐Yes ☐ No**

**E-MAIL REFERRAL TO:**

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Marjorie.Krohn@hhsnassaucountyny.us
JamieLee.Essig@hhsnassaucountyny.us
John.Imhof@hhsnassaucountyny.us

**FAX REFERRAL TO:**

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Nassau County Department of Social Services
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(516) 227-8012
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