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.)

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

Is patient a veteran? ☐Yes ☐ No

E-MAIL REFERRAL TO:

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