Suffolk County DSS Hospital Homeless Discharge Referral Form  
(For Suffolk County Hospitals and Medical Facilities Only)

### Hospital Homeless Discharge Referral Process

All discharges from Suffolk County medical facilities resulting in a referral to Suffolk County DSS will require this form be completed and emailed to: SCDSS_PRI@suffolkcountyny.gov along with the Patient Review Instrument (PRI). Suffolk County DSS will respond within 48 hours. Suffolk County DSS will no longer be able to accept telephone discharge requests. Patients who require assistance in the activities of daily living cannot be discharged directly to the Department of Social Services for Temporary Housing Assistance.

*The district where the patient is located when they are in need of assistance is considered to be the “where found” district pursuant to OTDA directive 00-INF-19. The medical facility or hospital from where the patient is being discharged must contact their local Social Services District for housing assistance.*

### Hospital Information

10 CRR-NY 405.9

The hospital shall ensure that each patient has a discharge plan which meets the patient’s post-hospital care needs. No patient who requires continuing health care services in accordance with such patient discharge plan may be discharged until such services are secured or determined by the hospital to be reasonably available to the patient.

<table>
<thead>
<tr>
<th>Date:</th>
<th>Medical Facility Name:</th>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Name of Hospital Discharge Planner completing this form:</th>
<th>Email Address:</th>
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</thead>
</table>
## Patient’ Name and Information

<table>
<thead>
<tr>
<th>Patient’s Name</th>
<th>DOB:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient’s First Name</td>
<td>Patient’s Last Name</td>
</tr>
<tr>
<td>SSN:</td>
<td>Veteran Status</td>
</tr>
<tr>
<td>☐ YES</td>
<td>☐ NO</td>
</tr>
</tbody>
</table>

### Patient’s address prior to entering the hospital:

**Can the patient return to this address?**
- ☐ YES
- ☐ NO

**If No, Why?**

### Is the patient currently receiving government funded benefits? (Mark all the apply)

- ☐ Suffolk County THA (Housing)
- ☐ Suffolk County TA
- ☐ Suffolk County SNAP
- ☐ Suffolk County MA
- ☐ SSI
- ☐ THA/TA/SNAP/MA in another NYS district
- ☐ THA/TA/SNAP/MA in another State

List SCDSS Case numbers or CINS:

- Enter Case/CIN number ___________
- Enter Case/CIN number ___________
- Enter Case/CIN number ___________

### Does the patient have income?

- ☐ YES
- ☐ NO

**If Yes, Amount and Type of Income?**

### Does the patient have Resources/Bank Accounts/Cash on Hand?

- ☐ YES
- ☐ NO

**If Yes, the amount and type of resources?**

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**THA (Temporary Housing Assistance) is a benefit authorized through the TANF/SN government programs to only those individuals who are eligible. THA/TA is an income based program. Eligibility is determined by evaluating available resources and income.**

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## Patient’s Health Related Information

<table>
<thead>
<tr>
<th>Hospital Admission Date</th>
<th>Proposed Hospital Discharge Date:</th>
</tr>
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</table>

### Does the patient need to receive after care / follow up care?

- ☐ YES
- ☐ NO

### Is the patient able to care for himself/herself without assistance and live completely independent?

- ☐ YES
- ☐ NO

**Single individuals seeking SCDSS Temporary Housing Assistance must:**

- Be able to prepare meals and eat without assistance
- Be able to transition to and from the bed and toilet without assistance
- Be able to shower and/or bathe without assistance
- Be able to monitor and take their own medication
- Not have a contagious or communicable disease, open wounds or MSRA

Any hospital patient discharged to SCDSS Emergency Housing that does not meet the criteria listed above will be sent back to the discharging hospital for their own safety.

**10 CRR-NY 400.13 PRI (Patient Review Instrument)**


Please email the completed PRI along with this form to: SCDSS_PRI@suffolkcountyny.gov

<table>
<thead>
<tr>
<th>Does the patient have known mental health issues?</th>
<th>Does the patient have known Drug and Alcohol issues?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ YES</td>
<td>☐ NO</td>
</tr>
</tbody>
</table>
Patient’s Disclosure

Please ask the Patient the following questions and have him/her sign this section.

Have you ever been convicted of a sex offense?  
☐ YES  ☐ NO

Are you currently on a Sex Offender Registry in any state?  
☐ YES  ☐ NO

If Yes, what is your level?  
☐ Undetermined  ☐ Level I  ☐ Level II  ☐ Level III

Are you currently on parole or probation for any reason?  
☐ YES  ☐ NO

If Yes, who is your parole or probation officer?
Name: ____________________________________
Address: __________________________________
Phone Number: ____________________________

RELEASE OF INFORMATION

I, ________________, hereby authorize the Suffolk County Department of Social Services to contact any appropriate law enforcement authorities concerning the information provided on this form.

Signed: ___________________________________ Date: ________________
(Patient’s Signature)
Witnessed by: ________________________________

Patient’s Release of Information

I HEREBY CONSENT TO COMMUNICATION BETWEEN:

The staff of ________________________________ and Personnel at Suffolk County Department of Social Services.

For the purpose of determining my eligibility for Temporary Housing Assistance.

This authorization shall be in force and effect until one (1) year after the date below at which time this authorization to disclose protected health information shall expire.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Practitioner at the address above. I understand that a revocation is not effective to the extent that the Practitioner has relied on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by HIPAA or any other federal or state law.

The entities listed above will not condition my treatment/care on whether I provide an authorization for disclosure except if health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

X

Signature of the Patient Date

X

Signature of the Hospital Discharge Planner Date