



# COUNTY OF SUFFOLK

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SUFFOLK COUNTY EXECUTIVE

## 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](mailto: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.*

<b>Date:</b>	<b>Medical Facility Name:</b> Enter Name of Hospital and Town Here
<b>Name of Hospital Discharge Planner completing this form:</b> Enter Hospital Discharge Planner's Name Here	<b>Email Address:</b> Enter Hospital Discharge Planner's Email Here
Has a SPA Application been completed for this patient ? YES      NO      If Yes, Date SPA application was submitted?	

Check all that apply. Patient has the following services in place:

None      AOT      ACT      Care Coordinator      Case Management Services:

Case Managers Name:      Phone #      Organization:

I, \_\_\_\_\_ give Suffolk County DSS and the Hospital Discharge Planner permission to discuss my case with my case manager to ensure an appropriate housing placement.

Patient Signature \_\_\_\_\_

Patient' Name and Information			
Patient's Name		DOB:XX/XX/XXXX	
Enter Patient's First Name Here	Enter Patient's Last Name Here	SSN: Last 4 digits	Veteran Status <input type="radio"/> YES <input type="radio"/> NO
Patient's address prior to entering the hospital: Enter Street, Town and State			
Can the patient return to this address? Enter Patient's Last Address Here  <input type="radio"/> YES <input type="radio"/> NO			
If No, Why? Enter Why the Patient is Homeless Here			
Does the patient have any income or resources?                      YES                      NO			
<p><b>Hospital Discharge Planners need to be aware that Temporary Housing Assistance (THA) is a benefit authorized through the Temporary Assistance government programs to only those individuals who are eligible. Eligibility is determined by evaluating an individual's income and available resources. Not everyone applying for Temporary Housing Assistance is determined to be eligible.</b></p>			

Patient's Health Related Information	
Hospital Admission Date:	Proposed Hospital Discharge Date:
Does the patient need to receive after care / follow up care? <input type="radio"/> YES <input type="radio"/> NO    If YES; Date of follow up appointment                      Location of follow up appointment	
Is the patient able to care for himself/herself without assistance and live completely independent? <input type="radio"/> YES <input type="radio"/> NO    Please Explain	
<p><b>Single individuals seeking SCDSS Temporary Housing Assistance must:</b></p> <ul style="list-style-type: none"> <li>• Be able to prepare meals and eat without assistance</li> <li>• Be able to transition to and from the bed and toilet without assistance</li> <li>• Be able to shower and/or bathe without assistance</li> <li>• Be able to monitor and take their own medication</li> <li>• Not have a contagious or communicable disease, open wounds or MRSA</li> </ul> <p>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.</p> <p><b>10 CRR-NY 400.13 PRI (Patient Review Instrument)</b>  <a href="https://www.health.ny.gov/forms/doh-694.pdf">https://www.health.ny.gov/forms/doh-694.pdf</a>  <a href="https://www.health.ny.gov/forms/instructions/doh-694_instructions.pdf">https://www.health.ny.gov/forms/instructions/doh-694_instructions.pdf</a></p> <p>Please email the completed PRI along with this form to: <a href="mailto:SCDSS_PRI@suffolkcountyny.gov">SCDSS_PRI@suffolkcountyny.gov</a></p>	
Does the patient have known mental health issues? <input type="radio"/> YES <input type="radio"/> NO If Yes, please explain briefly	Does the patient have known Drug and Alcohol issues? <input type="radio"/> YES <input type="radio"/> NO If Yes, please explain briefly

**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.

<b>X</b>	
<b>Signature of the Patient</b>	<b>Date</b>

<b>X</b>	
<b>Signature of the Hospital Discharge Planner</b>	<b>Date</b>