



**DHS SHELTER/OUTREACH REFERRALS: DISCHARGE PLANNING WORKSHEET**

**ATTENTION:** DHS requires that all possible placement avenues are explored, prior to discharge, and that a shelter placement or referral to outreach teams is seen as the last resort. For at-risk individuals on inpatient psychiatric units, who are eligible for supportive housing, an HRA 2010e application, psychosocial, and the HRA approval letter are to be completed, for every eligible client, prior to discharge. Refer to the next page for street homeless specific questions. There is also space for notes on the reverse page.

<hr/> <b>Hospital/Facility name</b>	<hr/> <b>SW/RN/Discharge Planner Contact Name and Phone</b>
<hr/> <b>Patient Name</b>	<hr/> <b>HA#/SS#/DIN#</b>

1. Detail nature and course of homelessness, indicating change in living situation, inclusive of dates and timeframes.
2. Document where the patient lived, prior to hospitalization, and why the patient cannot return there. If patient is street homeless, contact the borough's Outreach team to confirm if a client is known to a team, and determine the patient's willingness to go to a shelter. If pt is on Parole or Probation, include Correctional Facility, date of release, period of incarceration, nature of crime, sexual offender status, & OMH risk level.

3. Detail current benefits and list of any applications for the following benefits submitted during this hospitalization.

<b>Medicaid</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Applied <input type="checkbox"/>	<b>Public Assistance</b>	Yes <input type="checkbox"/>	\$ _____	No <input type="checkbox"/>	Applied <input type="checkbox"/>
<b>Medicare</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Applied <input type="checkbox"/>	<b>SSI/SSD</b>	Yes <input type="checkbox"/>	\$ _____	No <input type="checkbox"/>	Applied <input type="checkbox"/>
<b>HRA 2010e (NY NY)</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Applied <input type="checkbox"/>	<b>Food Stamps</b>	Yes <input type="checkbox"/>	\$ _____	No <input type="checkbox"/>	Applied <input type="checkbox"/>
<b>Veterans Benefits</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	\$ _____					

4. Detail all efforts made to place patient outside the shelter system (i.e., to previous residence, with family or friends in or out of state, in private homes, Supportive Housing, SRO, Nursing Homes, Assisted Living Facilities, State Psychiatric Centers, etc) and provide outcomes and follow-up on all residences for which patient was on waiting lists. Justify if no efforts were made for otherwise eligible individuals. If the patient is street homeless, detail contacts made with outreach teams and plans discussed.

5. If this client was placed under AOT, was the court order received and Citywide ICM requested? Yes  No
6. Did patient allow contact with family, friends or community supports? Yes  No   
If yes, provide full details/documentation of meetings or conversations:

7. If patient was evicted from his/her apartment, provide all of the details around the reported eviction and indicate whether it was a formal eviction. Was the landlord contacted, etc? If this patient is at risk of becoming homeless, was a *HomeBase* referral made?



8. List any housing applications that hospital has submitted, indicating if the patient has an interview scheduled. Attach additional page(s) as needed. If it was difficult to place pt in supportive housing, documented contact with CUCS is required.

9. If patient has advanced HIV disease or AIDS, was the patient referred to HASA? What was the outcome?

10. Detail any involvement with other organizations, departments, or government agencies (i.e., CUCS, APS, ACS, Parole, Brad H, OMH, HASA, HomeBase Prevention, etc.).

**REFERRALS TO OUTREACH – FILL OUT FOR STREET HOMELESS INDIVIDUALS ONLY**

(This information can be obtained through patient's self-report and/or through hospital records.)

1. Length of time on the Streets/Parks/Subways over last two years:
2. Length of time on the Streets/Parks/Subways over lifetime:
3. Location (Streets/Parks/Subways ) where patient sleeps when not hospitalized (as specific as possible):

**ADDITIONAL DISCHARGE PLANNING NOTES:**

**ATTESTATION OF DISCHARGE PLANNING EFFORTS:**

The patient's full range of non-shelter housing options has been explored and the Treatment Team has found no viable, safe alternative to shelter for the patient.

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Signature of Treatment Team Member

Date