

Encompass Health Rehabilitation Hospital of Bakersfield

Policy#: 325	Title: Homeless Discharge Planning (CA)	Category: Case Management
Policy Status: Published	Effective Date: 03/30/2020	Last Reviewed Date: 08/29/2025

PURPOSE

The purpose of this policy is to help prepare the homeless patient for return to the community by connecting him or her with available community resources, treatment, shelter, and other supportive services.

RESPONSIBILITY

It is the responsibility of the Interdisciplinary Team to adhere to this policy.

POLICY

This policy applies to patients discharged from an Encompass Health inpatient rehabilitation hospital in the state of California.

Housing status will not be used to discriminate against a patient or prevent medically necessary care or hospital admission.

1. The Case Manager assigned to the patient will assess each patient's living situation to determine if the patient is homeless during the Case Management Initial Assessment. A homeless patient is an individual who

- Lacks a fixed and regular nighttime residence, or
- Has a primary nighttime residence that is a supervised publicly- or privately-operated shelter designed to provide temporary living accommodations, or
- Is residing in a public or private place that was not designed to provide temporary living accommodations or to be used as a sleeping accommodation for human beings

2. The Case Manager will document the patient responses to assessment questions regarding living situation. The Case Manager will document if a patient refuses to answer assessment questions regarding their living situation in the Case Management Initial Assessment and/or Case Management Note.

3. Information will be provided to the homeless patient in culturally competent manner.

4. The Case Manager will prepare an individual discharge plan for each homeless patient. Discharge planning will be guided by the best interests of the homeless patient, his or her physical and mental condition, and his or her preferences for placement.

A post-discharge destination will be identified for each patient as the anticipated discharge plan. The post-discharge destination may be:

1. A social services agency, nonprofit social services provider, or governmental services provider that has agreed to accept the patient. The Case Manager must document the name of person at the receiving agency

or shelter who agreed to accept the patient. The Case Manager must send the receiving entity written or electronic information about the patient's post-discharge health and behavioral health needs. (If the hospital already uses a form to document the patient's post-discharge needs, the hospital may specify that a copy of that form will be emailed or sent in another way to the receiving agency.)

2. The homeless patient's "residence," which is defined as "the location identified to the hospital by the patient as his or her principal dwelling place."

3. An alternative destination, as indicated by the homeless patient.

The hospital will not "cause the transfer" of a homeless patient to another county for the purpose of receiving supportive services from a social services agency, health care service provider, or nonprofit social services provider in the other county, unless the hospital has received prior authorization from the receiving entity to accept the specific patient.

Each homeless patient will be offered the following services prior to discharge:

1. The patient will be offered a physical exam and the physician will determine the patient's stability for discharge.
2. The patient will be given referrals for any needed follow-up care, both medical and behavioral, as determined by the treating physician.
3. The patient will be offered a meal.
4. If the patient's clothing is not weather-appropriate, the patient will be offered weather-appropriate clothing.
5. The patient will be provided discharge prescriptions as determined by the treating physician.
6. The hospital will offer homeless patients or refer homeless patients for infectious disease screening.
7. The patient will be offered vaccinations appropriate to his or her presenting medical condition, as determined by the treating physician.
8. The patient will be offered transportation to his or her chosen discharge destination, if that destination is within 30 miles or 30 minutes of the hospital.
9. The patient will be screened for, and helped to enroll in, any affordable health insurance coverage for which he or she is eligible.
10. The Case Manager assigned to the homeless patient will complete a "Homeless Patient Discharge Planning Worksheet" prior to the patient's discharge from the hospital. This form will be scanned into the medical record.
11. The patient has the right to refuse any or all post-discharge services offered by the hospital. Patient refusal will be documented in the medical record by the Case Manager.

Close



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To Whom It May Concern,

HCAI California Hospital Equity Measures Reporting

Every calculation associated with all report fields has been evaluated for our hospital. While this AB 1204 Equity Report may appear sparsely populated and lacking values in some areas, this reflects the complexity of the reporting requirements—not a deficiency in the report itself. Many blank cells are the result of limited availability of certain stratification variables. Our hospital remains committed to advancing equity reporting and looks forward to additional regulatory guidance on whether and how these data elements should be collected in the future. Even when the final numbers are few, the work behind them is substantial—and necessary for accurate and compliant reporting.

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