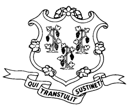

W-265
(Rev. 6/17)

STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES

REPORT OF ADMISSION OR DISCHARGE
RATED HOUSING FACILITY/RESIDENTIAL CARE HOME

Client Name: ____________________________ Client ID#:______________________

Facility Name: ___________________________ Vendor ID#:_____________________

Facility Address: ___________________________________ Facility ph#: ____________

☐ADMISSION

Date of Admission: _____________________________________

Admitted From: ☐Home ☐Hospital ☐Skilled Nursing Facility/Chronic Disease Hospital

☐Other Rated Housing Facility ☐ICF/IDD ☐Other Setting/Institution

Please provide the name and address of the home, institution or facility from which the individual was admitted: ____

☐DISCHARGE

☐Notice of Permanent Discharge Date of Discharge:___________________________

☐Notice of Temporary Discharge Date of Discharge: ___________________________

If a temporary discharge, is the individual expected to return by the last day of the month following the month of discharge? ☐Yes ☐No

If no, when is the individual expected to return __________________________________

Are you holding the bed for this individual? ☐Yes ☐No

Discharged to: ☐Home ☐Hospital ☐Skilled Nursing Facility/Chronic Disease Hospital

☐Other Rated Housing Facility ☐ICF/IDD ☐Other Setting/Institution

Please provide the name and address of the home, institution or facility to which the individual was discharged:____

Completed by: ____________________________ Date: ___________________________
Print Name

____
Signature

This form is not a request for assistance. Please notify the Department of Social Services (DSS) **within 10 days** of any changes in living arrangements for DSS clients.

To order additional forms, send request on your agency letterhead to:
DSS, Document Center, 55 Farmington Ave., Hartford, CT 06105 FAX: (860) 424-4954
Please include a complete mailing address, form number and the quantity needed.
Please note forms cannot be mailed to P.O. Boxes.

Persons who are deaf or hard of hearing and have a TTD/TTY device can contact DSS at 1-800-842-4524. Persons who are blind or visually impaired, can contact DSS at 1-860-424-5040.

INSTRUCTIONS FOR FORM W-265

I. INTRODUCTION

Form W-265 is used by the Rated Housing Facility/Residential Care Home to notify the Department (1) when an individual is admitted to the home or facility, (2) when an individual is discharged from the home or facility (regardless of whether the discharge is temporary or permanent) and (3) when there is a change in discharge status from temporary to permanent.

II. SPECIFIC INSTRUCTIONS

A. The Rated Housing Facility/Residential Care Home will complete Form W-265 by printing or typing as follows:

1. **Client Name** - Enter the individual's complete name.
2. **Client Number** - Enter the complete client identification number assigned to individual by DSS, or if a number has not yet been assigned, note that the application is pending.
3. **Facility Name/Address/Phone** - Enter the complete name, address and phone number of your facility.
4. **Vendor ID #** - Enter the complete vendor number assigned to your facility.
5. **Notice of Admission**- Check the box if you are reporting an admission.
6. **Date of Admission** - Enter the date of admission in MM/DD/YY format.
7. **Admitted From** - Check the appropriate box. Indicate the name and address of the institution or home address admitted from.
8. **Notice of Permanent Discharge** – Check the box if you are reporting a permanent discharge. Indicate the name and address of the setting to which the client was permanently discharged.
9. **Notice of Temporary Discharge** - Check the box if you are reporting a temporary discharge. Indicate the name and address of the setting to which the client was temporarily discharged.
10. **Date of Discharge** – Enter the date of discharge in MM/DD/YY format.
11. **If temporary, is individual expected to return by end of next month?** – Check the box based on the information available at the time of discharge. If no, enter the expected date of return in MM/DD/YY format.
12. **Are you holding the bed for this resident?** - Check the appropriate box.
13. **Completed by** – Enter the name and signature of the representative from the Rated Housing Facility/Residential Care Home completing the form and the date the form was completed in MM/DD/YY format.

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