

Date: \_\_\_\_\_

Monroe County Department of Human Services  
1111 Westfall Road  
Rochester, NY 14620

Re: \_\_\_\_\_

DOB: \_\_\_\_\_

To Whom it May Concern:

Please be advised that \_\_\_\_\_ was  
discharged from \_\_\_\_\_ on \_\_\_\_\_.

He/She will be residing at the following address:

\_\_\_\_\_  
\_\_\_\_\_

He/She is in need of the following items to meet current treatment  
expectations:

Temporary Medicaid Card (copies of prescriptions attached)

\_\_\_\_\_

Transportation (accessed through Temporary Medicaid Card)

\_\_\_\_\_

Sincerely,

\_\_\_\_\_

Signature

\_\_\_\_\_

Phone Number