

By Senator Rouson

16-00991B-26

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A bill to be entitled

An act relating to procedures for discharging persons to avoid homelessness; providing a short title; amending s. 420.626, F.S.; revising legislative intent; encouraging certain facilities and institutions, in collaboration with a continuum of care lead agency, to develop and implement certain procedures for when persons are discharged from certain facilities or institutions; requiring the Department of Children and Families to conduct a pilot program in specified counties; requiring the department to submit certain quarterly and, beginning on a specified date, annual reports to the Governor and the Legislature; revising certain procedures; defining the term "client-level data"; requiring the sharing of client-level data to comply with specified state and federal laws and regulations; requiring a continuum of care lead agency to evaluate certain procedures and identify gaps and opportunities for improvement in its annual continuum of care plan; authorizing the State Office on Homelessness, in conjunction with the Council on Homelessness, to provide guidance to a continuum of care lead agency for a specified purpose; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. This act may be cited as the "Bridging Systems to Housing Act."

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30 Section 2. Section 420.626, Florida Statutes, is amended to
31 read:

32 420.626 Homelessness; discharge guidelines.—

33 (1) It is the intent of the Legislature, ~~to encourage~~
34 ~~mental health facilities or institutions under contract with,~~
35 ~~operated, licensed, or regulated by the state and local~~
36 ~~governments to ensure, to the extent practicable, that persons~~
37 ~~leaving the their care or custody of hospitals and other~~
38 ~~facilities and institutions under contract with, operated by,~~
39 ~~licensed by, or regulated by the state and local governments~~ are
40 not discharged into homelessness ~~without connecting such persons~~
41 ~~to the continuum of care.~~

42 (2) The following facilities and institutions, in
43 collaboration with the continuum of care lead agency in the
44 facility's or institution's catchment area, are encouraged to
45 develop and implement procedures as provided under subsection
46 (4) which are designed to reduce the discharge of persons into
47 homelessness when such persons are admitted or housed for more
48 than 24 hours at such facilities or institutions: hospitals and
49 inpatient medical facilities not located in a county in which a
50 pilot program is conducted under subsection (3); crisis
51 stabilization units; residential treatment facilities; assisted
52 living facilities; and detoxification centers.

53 (3) The department shall conduct a pilot program in
54 Broward, Duval, Hillsborough, and Pinellas Counties for the
55 development and implementation of the procedures required under
56 subsection (4) for all hospitals and inpatient medical
57 facilities located in those counties.

58 (a) Until the pilot program is fully implemented, the

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59 department must submit to the Governor, the President of the
60 Senate, and the Speaker of the House of Representatives
61 quarterly reports on the status of the pilot program in each
62 designated county.

63 (b) By November 30, 2027, and annually thereafter, the
64 department shall assess and submit a report on the effectiveness
65 of the pilot program in each designated county to the Governor,
66 the President of the Senate, and the Speaker of the House of
67 Representatives.

68 (4) (3) The procedures for persons who consent to
69 participate in services must should include all of the
70 following:

71 (a) Development and implementation of an early assessment &
72 screening process or other mechanism for identifying persons to
73 be discharged from the facility or institution who reported
74 being homeless at the time of intake, are at considerable risk
75 for homelessness, or face an some imminent threat to their
76 health and safety upon discharge.

77 (b) Development and implementation of a discharge plan that
78 ensures addressing how identified persons are offered a
79 transition from the facility or institution to the local
80 continuum of care for connection to housing or shelter
81 resources, if available, or supportive services will secure
82 housing and other needed care and support upon discharge.

83 (c) Communication with the entities to whom identified
84 persons may potentially be discharged to determine their
85 capability to serve such persons and their acceptance of such
86 persons into their programs, and selection of the entity
87 determined to be best equipped to provide or facilitate the

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88 provision of suitable care and support. A discharge to an entity
89 may only occur during normal operating hours when the receiving
90 entity is open to receive the discharged person.

91 (d) Coordination of effort and sharing of information with
92 entities that are expected to bear the responsibility for
93 providing care or support to identified persons upon discharge
94 through the following processes:

95 1. Enrollment in the Homeless Management Information System
96 to collect and share client-level data in order to gain an
97 understanding of an identified person's characteristics,
98 eligibility, and needs for housing and related services; or

99 2. With an identified person's consent, development and
100 implementation of a process or mechanism to share client-level
101 data regarding a person's medical and mental health needs
102 outside of the Homeless Management Information System.

103

104 As used in this paragraph, the term "client-level data" means
105 detailed, individual-level information regarding the housing and
106 other relevant needs, such as mental health support, of a person
107 being discharged from a facility or institution. Client-level
108 data sharing is used to ensure the timely, continuous, and
109 coordinated delivery of housing-related services and supports
110 after an identified person is stabilized and before the person
111 is released from the facility or institution. The sharing of
112 client-level data must comply with federal and state privacy and
113 confidentiality laws and regulations.

114 (e) Provision of sufficient medication, medical equipment
115 and supplies, clothing, transportation, and other basic
116 resources necessary to ensure that the health and well-being of

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117 identified persons are not jeopardized upon their discharge.

118 (f) Development and implementation of a process for
119 facilities and institutions to verify in the Homeless Management
120 Information System whether a person is registered with the
121 continuum of care and, if so, the entry of a referral in the
122 Homeless Management Information System for such person. If a
123 person is identified at intake as homeless or is at considerable
124 risk of homelessness upon discharge, but the person is not
125 registered in the Homeless Management Information System, the
126 facility or institution must ensure such person contacts the 211
127 call center or other local nonemergency service referral hotline
128 to facilitate registration in the Homeless Management
129 Information System in order to receive a referral to the
130 continuum of care's coordinated entry system.

131 (g) Provision of information, such as a website or other
132 resource guides if available, to identified persons regarding
133 resource availability through the 211 call center, any other
134 local nonemergency service referral hotline, or the continuum of
135 care.

136 (5) The continuum of care lead agency shall evaluate the
137 procedures developed and implemented under subsection (4) and
138 identify gaps and opportunities for improvement in its annual
139 continuum of care plan submitted to the State Office on
140 Homelessness. The State Office on Homelessness, in conjunction
141 with the Council on Homelessness, may provide the continuum of
142 care lead agency guidance to address ongoing gaps in services to
143 strengthen local discharge planning practices.

144 (6) (4) This section is intended only to recommend model
145 guidelines and procedures that mental health facilities or

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146 ~~institutions under contract with or operated, licensed, or~~
147 ~~regulated by the state or local governments may consider when~~
148 ~~discharging persons into the community.~~ This section is not an
149 entitlement, and no cause of action shall arise against the
150 state, the local government entity, or any other political
151 subdivision of this state for failure to follow any of the
152 procedures or provide any of the services suggested under this
153 section.

154 Section 3. This act shall take effect July 1, 2026.