

## Adult Behavioral Health Home & Community Based Services and CORE Referral Form

Date of Referral: \_\_\_\_\_

<b>Referring Person</b>	First Name		Last Name	
	Agency Name		Phone #	
	Address		E-mail	
<b>HH Care Mgr/ Service Coordinator Information</b>	First Name		Last Name	
	Agency Name		Phone #	
	Address		E-mail	
<b>HCBS Participant Information</b>	First Name		Last Name	
	Soc. Sec. #		Address	
	Phone #		Alt. Phone #	
	E-mail		Date of Birth	
	Prim. Language			
<b>HCBS Participant Health Care Information</b>	MCO Name		Policy ID #	
	MCO Contact Name		MCO Telephone Number	
	MCO Contact E-mail		Medicaid CIN Number	
	Prim. Diagnosis & ICD 10 Code		Secondary Diagnosis & ICD 10 Code	
Any Known Safety Concerns? (Criminal Record, History of Violence, Weapons in the Home, Sex Offender, Bed Bugs, etc.):				N/A

<b><u>HCBS Service(s):</u></b>	<b><u>CORE Service(s):</u></b>
Habilitation	Psychosocial Rehabilitation
Pre-Vocational Services	Empowerment Services (Peer Support)
Ongoing Supported Employment	PSR w/Education
Intensive Supported Employment	PSR w/ Employment
Education Support	Family Support and Training
Any Identified Service Restrictions Surrounding Client Availability? <span style="float: right;">N/A</span>	

### AGENCY INFORMATION

**AGENCY NAME:** \_\_\_\_\_ **POINT OF CONTACT:** \_\_\_\_\_  
**PHONE:** \_\_\_\_\_ **FAX:** \_\_\_\_\_ **EMAIL:** \_\_\_\_\_

*Programs and Services:*  
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 585.546.7220 585.339.9800

*Regional Office:*  
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 315.536.2370