Adult Home & Community Based Services (HCBS) and / or Community Oriented Recovery & Empowerment Services (CORE) Referral

Date of Referral: ________________	Return Completed Referral	Mail	609 W. Washington St. Geneva, NY 14456
		Fax	(315)789.0555
		Email	HCBSCORE@lakeviewhs.org

HCBS / CORE Participant Information	First Name		Last Name	
	Address		Phone	
			Alt. Phone	
	Date of Birth		Email	
	Primary Language		Gender Identity	

Anything we should know? (Recent Incarceration, History of Violence, Weapons in the Home, Sex Offender, Dog in Home, Bed Bugs, etc.):	N/A [ ]	Best Contact Method	[ ] Phone [ ] Email

Participant Insurance Information	MCO Name		Subscriber ID#	
	Contact Name		Contact Phone	
	Contact Email		Medicaid CIN#	
	Primary Diagnosis & ICD 10 Code		Secondary Diagnosis & ICD 10 Code	

Care Management Information	CM Name		Agency	
	Phone		Address	
	Email			
	[ ] N/A	Not required for CORE Services	Is this a self-referral? (CORE only)	Yes [ ] No [ ]

Referral Source Information	Source Name		Agency	
	Phone		Address	
	Email			

Care Team Information	Primary Care Name		Phone	
	Therapist Name		Phone	

Services Requested – Please Check All That Apply			
Home & Community Based Services		Community Oriented Recovery & Empowerment Services	
Habilitation Services			Empowerment – Peer Support Services
• For HCBS Services please include Level of Service Determination and MCO Approval Letters • For CORE Services please include LPHA Recommendation Letter if available			Psychosocial Rehabilitation Services
			PSR with Educational and / or Employment Supports

Primary Goal for Services:	

Agency Use			
Date Received		Date Forwarded	☐ Admission to Foothold ☐ Admission Note complete ☐ Upload referral to profile
Forwarded To			