**Date Referral Being Made: ­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |
| --- | --- | --- | --- |
| Person being referred: |  | Person making referral: |  |
| Parent/Guardian name(s): |  | Phone: |  |
| Phone: |  | Cell Phone: |  |
| Cell Phone: |  | E-mail: |  |
| Address: |  | Agency & Address: |  |
| County of Residence: |  | Case/Care Manager: |  |
| Age / Sex: |  | Contact Information: |  |
| Date of Birth: |  | Mental Health Diagnosis: |  |
| Race: |  | High Risk Behavior(s): |  |
| Preferred Language: |  | Aggression: |  |
| School/Grade: |  | Alcohol / Drug use: |  |
| Date of most recent ED/CPEP Visit or Hospitalization: |  | Self-Injury behavior: |  |

**Please list your current supports:** Include family, community supports, and agencies providing services. DSS / CPS involvement (past or present), current HCBS Services:

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

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| **Services being requested** | **Check Box** | **Services Being Requested** | **Check Box** |
| Skill Building/Prevention of Hospitalization |  | Socialization/ Recreation |  |
| Medication Coordination/Education/Assistance |  | Activities of Daily Living Support/Training |  |
| Crisis Support/Linkage |  | Assistance with accessing Housing Options |  |
| Transitional support from inpatient/incarceration to community setting |  | Assistance with available Community Resource’s for Transportation/Benefits |  |
| Access to Crisis Respite (Children & Adult) |  | Geriatric support/consultation |  |
| Peer Support (Adult) |  |  |  |

**Please provide a brief summary of current behaviors/symptoms and rationale for services requested:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please fax or e-mail this referral to:**

**FAX: 607-763-2792**

[Sheena.Fenescey@omh.ny.gov](mailto:Sheena.Fenescey@omh.ny.gov) or call 607-763-2761

(Broome ,Chenango, Delaware, Otsego, Tioga, Tompkins)

[Janet.Dunbar@omh.ny.gov](mailto:Janet.Dunbar@omh.ny.gov) or call 607-737-4944

(Allegany, Steuben, Schuyler, Chemung, Tioga, Tompkins)

[Scott.Pranis@omh.ny.gov](mailto:Scott.Pranis@omh.ny.gov) or call 315-350-0289

(Wayne, Ontario, Seneca, Yates)

**1-844-HELPMIT**