greater mental health of New York

Referral Form

Children and Family Treatment and Support Services

(For office use)
Date Received:
Date Assigned:

Children and Family Treatment and Support Services (CFTSS)
Referral for Services

Email completed forms via encrypted email to mocciok@mhawestchester.org
For questions, please contact Kathy Moccio at 914-703-8021 or mocciok@mhawestchester.org.

Date:_____
Child's Name:_____ Date of Birth:_____
Gender: _____ Preferred Language: _____Phone Number:_____
Address:_____
Parent/Guardian Name and Phone Number (if different than above):
_____
Medicaid CIN#:_____ Managed Care Plan:_____

Referral Source Information:
Name:_____ Phone Number:_____
Email address:_____
Relationship:_____ Agency (if applicable):_____
Reason for referral:
_____
_____

Services being requested:

- ☐ Other Licensed Practitioner (OLP)
- ☐ Community Psychiatric Supports and Treatment (CPST)*
- ☐ Psychosocial Rehabilitation (PSR)*
- ☐ Family Peer Support Services (FPSS)*
- ☐ Youth Peer Support and Training (YPST)*
- ☐ OLP Licensed Evaluation

***If you are a Licensed Practitioner of the Healing Arts (LPHA) recommending CPST or PSR, please complete the following page. **I am a (check one):**

- ☐ Registered Nurse Professional Nurse Practitioner
- ☐ Psychiatrist
- ☐ Licensed Psychologist
- ☐ LMFT
- ☐ LMHC
- ☐ Physician
- ☐ Licensed Creative Arts Therapist
- ☐ Licensed Psychoanalyst
- ☐ Physician's Assistant
- ☐ LMSW
- ☐ LCSW

Recommendation for CFTSS Services
This page to be completed only by LPHAs (as detailed on previous page)
****Please complete all sections.****

Behavioral Health Diagnoses (Mental Health and/or Substance Use Disorders):

	Diagnosis Name	**Diagnosis Code**	**Dx Provided By**
Primary			
Secondary			
Other			

Areas of Functioning (As a result of the diagnosis listed above, the child/youth has functional impairment that interferes with or limits functioning in at least one of the following areas and is likely to benefit from and respond to the service(s) recommended to prevent the onset or worsening of symptoms.) **Check all that apply:**

Check	**Domain**	**Description of Impairment**
	Self-Direction/Control	
	Self-Care	
	Family Life	
	Social Relationships	
	Symptom Management	

Recommended CFTSS:

Check	**Domain**	**Description of Needed Intervention**
	Other Licensed Practitioner (OLP)	
	Community Psychiatric Supports and Treatment (CPST)	
	Psychosocial Rehabilitation (PSR)	
	Family Peer Support Services (FPSS)	
	Youth Peer Support and Training (YPST)	

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By signing below, I am recommending the above named individually for Children & Family Treatment and Support Services.

Print Name

_____	_____	_____
Signature, including credentials	NPI #	Date