Planned Respite Referral Form

Updated as of 5/2/2024

White Plains, NY 10605

(914) 948-4993

(914) 815-1540

FAX: 914-946-9303

Dear Applicant:

Thank you for your interest in Planned Respite.

Planned Respite is a short-term intervention strategy for adults who have a mental health or co-occurring diagnosis and who are experiencing an escalation of symptoms that cannot be managed in the person's home and in the community environment without increased supports. We offer a warm and supportive environment in which people are encouraged to use recovery and relapse prevention skills by specially trained counselors.

Services are voluntary and temporary, and are provided by trained staff in the participant's place of residence or at an alternate authorized temporary housing arrangement. It includes custodial care for a person in order to provide primary care givers (family, significant other, or legal guardian) relief from care responsibilities or supports to the individual to sustain stability in the community and avoid unnecessary hospitalization.

An individual can participate in Planned Respite services for a maximum of 14 nights annually.

Individuals requesting Planned Respite Services must complete a referral application and enclose the following:

· Psychiatric Evaluation (Current within 90 days)

· Psychosocial (Must support eligibility Determination)

Questions and/ or concerns regarding referrals should be made directly to Planned Respite Program Director at (914) 815-1540. Please contact Desh Edwards from Westchester's Department of Community Mental Health at 914-995-6753 or at dle1@westchestergov.com for approval. Once eligibility has been confirmed and approved by DCMH, Tanya Wilson, Greater Mental Health of New York's Program Director will contact you to discuss your respite care needs and coordinate accommodations.

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Name: _____ Date of Birth: _____

Social Security #: _____ Medicaid #:_____

Military Service: Yes _____ No _____

Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Male __ Female __

Citizenship: Yes _____ No_____ (if no, immigration status)_____

Care Manager (if Any)_____ Agency:_____

Ethnicity

____White (Non-Hispanic)
____Latino
____Black (Non-Hispanic)
____Native American
____Asian/Asian America
____Pacific Islander

Primary Language

____English
____Spanish
____Italian
____Russian
____German
____Japanese
____Other

Psychiatric Information:

Diagnosis DSM IV Codes

Axis I:_____ _____

Axis II:_____ _____

Axis III: Current Medical Problems

_____

Axis IV Diagnosis: psychosocial and environmental problems: Please list below

_____

Risk Assessment:

Cruelty to Animals_____

Suicidal Behavior_____

Fire Setting_____

Severe Violence_____

Homicidal Behavior_____

Sexual Offense_____

Current Medications: Please List Dosage and Frequency

_____

_____

_____

_____

Can participant self monitor medications? Yes_____ No _____

Any known allergies: Yes_____ No_____

If so, please list known allergies:_____

_____

Any food restrictions? _____

Special Dietary needs? _____

Outpatient Treatment Provider:

Agency:_____

Program:_____

Contact:_____

Telephone:_____

Substance Abuse History: Please List Drugs of Choice

_____

Length of Time Recipient Has Been Substance Free:_____

Criminal Justice – Current Status

None_____ Incarcerated-Jail

Incarcerated_____ Prison_____ CPL 330.20/730_____

Probation _____ Parole

TASC/MHATI_____ Other:_____

Assisted Outpatient Treatment

Does the person have court ordered AOT under Kendra's Law?

Yes_____ No_____

Reason for request for Planned Respite Services:

_____

_____

_____

Does participant require 24 hour supervision? Yes_____ No_____

Is the Participant requesting Planned Respite Services at their place of residence or at an alternate authorized temporary housing arrangement? (Please check one)

Participant's Residence_____ or Temporary housing arrangement_____

How many days are being requested:

_____

Start date for requested services:

_____

Geographic preference:_____

Emergency Supports and Contact information:

Name:_____

Address: _____

Phone: _____

Relationship:_____

Referral Source

Name:_____

Phone: _____

Agency_____

Fax: _____

Address: _____

Program: _____

Relationship:_____

Participant Signature:_____ _____Date:_____

I, _____, hereby Authorize Greater Mental Health of New York to release and/or receive information in order to Coordinate respite accommodations with either County housing providers or individual's home setting, inclusive of setting, staffing, and services. This information will be held for the sole purposes of coordinating Planned Respite Services for the individual listed above.

I am aware that this consent can be revoked or adjusted at any time to meet my needs. Any revocation or change must be initiated in writing and authorized by me. I understand that the information to be released is confidential and protected. Disclosure to any party other than the one designated above is not permitted.

Signature of Client or Parent/Guardian	Name of Signer	Relationship	Date Signed
_____	_____	_____	_____
Signature of Client or Parent/Guardian	Name of Signer	Relationship	Date Signed
_____	_____	_____	_____

You may review Greater Mental Health of New York's "Notice of Privacy Practices" for additional information about your rights regarding releasing of private health and medical information. Greater Mental Health reserves the right to change privacy practices in accordance with the law, which may change the terms of the Notice. A summary of the Notice is posted in each agency location indicating the effective date of the Notice. You were offered a copy of the Notice of Privacy Practices on your first visit at Greater Mental Health of New York. You may also receive another copy of the Notice if desired and requested.

As more fully explained in the Notice, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and health care operations purposes. In case of emergency, we may need to disclose information about you to ensure that you receive the treatment/care needed.