

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@greatermentalhealth.org

For questions, please contact Kathy Moccio at 914-703-8021 or mocciok@greatermentalhealth.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) | Family Peer Support Services (FPSS)* |
| Community Psychiatric Supports and Treatment (CPST)* | Youth Peer Support and Training (YPST)* |
| Psychosocial Rehabilitation (PSR)* | 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 | LMFT | Licensed Psychoanalyst |
| Professional Nurse Practitioner | LMHC | Physician's Assistant |
| Psychiatrist | Physician | LMSW |
| Licensed Psychologist | Licensed Creative Arts Therapist | 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