greater mental health of New York

Referral Form

Family Peer Support Services - Rockland

FAMILY PEER SUPPORTS REFERRAL FORM

Please complete and return via secure email to **smitha@greatermentalhealth.org**

PLEASE NOTE: Family Peer Supports (formerly "Network"), funded by Rockland County Department of Mental Health, is available to caregivers of children who do NOT have Medicaid.
***If you would like to refer a caregiver of a child with Medicaid and who has a mental health diagnosis, please refer to Children and Family Treatment and Support Services (CFTSS). Thank you.**

CHILD/YOUTH NAME				**DATE OF BIRTH**	
PARENT/GUARDIAN NAME				**Relationship to child**	
Phone Number		**Can we text this number?**	☐ YES ☐ NO	**Email Address**	
Child's Full Home Address *Approximate Move-in Date:*					
Ethnicity		**Race**		**Religion**	
Primary Language		**Gender Identity**		**Sex at Birth**	
School		**School District**		☐ IEP ☐ 504	**Grade**
Child's Commercial Health Insurance Carrier				**If ineligible for health insurance, please check box** ☐	
***If the child has Medicaid, please check box** ☐		**Medicaid ID**			
Other children in household (Please include ages)					
Adults in household					
Reason for referral/Behaviors of concern					
Expected outcome(s)					
Briefly describe child/youth's strengths					
Any immediate SAFETY concerns? ☐ YES ☐ NO	Comments:				
Diagnosis(es), if applicable					
Medication(s), if applicable					
Service(s) already in place					

greater mental health of New York

Referral Form

Family Peer Support Services - Rockland

Referral Source Name		**Referral Date**	
Program or Relationship to Child/Youth			
Email Address		**Phone Number**	

REFERRAL SOURCE: Please ensure the following is completed with the Parent/Guardian to coordinate Family Peer Support Services.

PARENT: We are requesting your permission to invite the individuals **YOU** list below to help with the planning of coordinated comprehensive services for your child and your family. Make sure to include all service providers (i.e. school staff, counselors, case managers, social services, probation, or other natural supports including family members and friends) you would like to participate. Consent will be obtained at the first Family Peer Supports meeting.

A Family Peer Advocate (FPA) will contact the parent prior to the meeting and will provide support throughout this process.

Name	Affiliation	Phone Number	Email

greater mental health of New York

Referral Form

Family Peer Support Services - Rockland

Children and Family Services
140 Route 303
Valley Cottage, NY 10989
Tel 914-598-6061 • Fax 845-268-0697

As required by the Health Information Portability and Accountability Act of 1996, Greater Mental Health of New York, Inc. may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures described herein.

AUTHORIZATION SECTION

I, _____ [parent/guardian name] request that Health information regarding care and treatment of _____ [Date of Birth: ___/___/_____] be released as set forth on this form.

By initialing here _____ I authorize, **CFS Staff** to discuss health information with the person or provider listed below.

Name, address and phone number of person or provider to disclose this information:
CFS Staff – Greater Mental Health of New York, 140 NY-303, Ste. E, Valley Cottage, NY 10989, 914-598-6061

Name, address and phone number of person(s) or provider to whom this information will be released:

_____

_____

Specific information to be released: (Please check all that apply)

- ☐ Complete clinical/Mental Health Record
- ☐ History and Treatment Plans
- ☐ Client Face Sheet
- ☐ Other: (please specify)
- ☐ Intake information
- ☐ Psychiatric Evaluation
- ☐ List of Medication

Include: (By initialing)

_____ Alcohol/Drug Treatment
_____ Mental Health Information
_____ HIV-Related Information

For the following purpose: (staff, please check all that apply)

- ☐ Billing
- ✓ Treatment
- ☐ Operations
- ☐ Other: _____

I understand this authorization will expire when my child is no longer receiving services from Greater Mental Health of New York, or on the following event, condition, or date: _____

I understand the persons receiving this information following this authorization are prohibited by federal and state law from disclosing the information any further.

I understand that I am under no obligation to sign this authorization. I further understand that if I do not sign this authorization my child's ability to obtain treatment will not be affected.

FORM MUST BE COMPLETED BEFORE SIGNING

I have read this form and any questions about the release of information have been answered. By signing below, I acknowledge that I have read and accept all the above.

_____
Print Name of Individual or Personal Representative

_____ _____
Signature of Individual or Personal Representative **Date**

_____ _____
Witness **Date**

This program participant or his/her representative must be provided with a copy of this form after it has been signed.
If opting out of receiving a copy, which may be requested at a later date, please initial here: _____

REVOCATION OF AUTHORIZATION TO RELEASE INFORMATION

I understand that I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to **Greater Mental Health of New York, Inc., 140 Route 303, Suite A, Valley Cottage, NY 10989 Attn: Compliance.** I further understand that such revocation does not apply to the extent that person or provider authorized to use or disclose my health information have already acted on this authorization.

I hereby cancel my permission to use/disclose information indicated above, as of this date: _____

_____ _____
Signature **Date**