Northeast Family Services

CFTSS and HCBS Referral Form

Please complete both pages.

Note that incomplete information may delay service delivery.

Date of Referral: _____

Youth Name: _____ DOB: _____ Known as: _____

Medicaid ID#: _____ Language required for services: _____ Sex: ___ Age (3-21): _____

Indicate Payer Type: _____

Guardian's Name: _____ Relationship to youth: _____

Guardian's Phone Number: _____ Address: _____

Town: _____ Zip Code: _____ Parent(s) name if different: _____

Member's of the household: _____

Referent Name: _____ Referring Agency: _____

Referent Phone: _____ Referent Email: _____

If HCBS- Has level of care and eligibility been determined? Yes or No (Please send copy of eligibility)

Has a CFTSS or HCBS referral been placed to another agency at the same time? If yes, which agencies? _____

_____

Has the client received CFTSS or HCBS services previously? If yes, which agency _____

Has the family voluntarily agreed to this referral? Y or N

Please list all Psychiatric Hospitalizations, Crisis Visits, or Risk Assessments that have occurred in past (1) one year:

_____

_____

_____

Risk for Re-Hospitalization: 1 2 3 4 5 (1= very low, 3=moderate, 5=very likely)

Check if Primary	ICD-10 Code	DSM-IV/DSM 5 Narrative Description (i.e. Major depressive disorder, single episode, moderate)

Other Current Providers (DSS, ACS, Preventive Services, Foster Care, Psychiatry, Individual Therapist, etc.):

Name	Service	Agency	Phone Number

Reason for Referral/Goals: (symptoms, behavioral/social/emotional functioning of youth/family, focus of treatment):

_____

_____

_____

_____

_____

Medications:

	Name	Dose	Frequency	Indication		Name	Dose	Frequency	Indication
1.					2.				

Family's Preference for Scheduling: SU M T W TH F SA Times: _____

Services being requested: Check all that apply

CFTSS : **OLP (Other Licensed Practitioner)** **CPST (Community Psychiatric Support and Treatment)**

PSR (Psychosocial Rehabilitation) **FPSS (Family Peer Support Services)**

YPSS (Youth Peer Support Services)

HCBS: **Caregiver/Family Support Services** **Community Self Advocacy Training & Support**

Pre-vocational (ages 14 or older) **Supported Employment (ages 14 and older)**

Reason **CFTSS or HCBS** Level of Care needed *(please check all that apply):*

☐ Outpatient services alone are not sufficient to meet youth and family's needs for clinical intervention

☐Need for increased frequency/duration/flexibility of family sessions depending on need in the home and community

☐Need for 24/7 urgent telephonic response and risk management/safety planning

☐Youth at risk for out-of-home placement

☐Need for care coordination with school, other providers, state agencies, natural supports, etc.

☐High level of risk factors (indicate below)

☐Need treatment to enhance youth's problem-solving, limit setting, and communication to sustain youth in home

☐Strengthen caregiver(s) ability to sustain youth in home

At-Risk Factors or Safety Concerns Present *(please check all that apply):*

☐ Suicidal Ideations

☐ Suicidal Gestures

☐ Self-Injurious Behaviors

☐ Homicidal Ideations

☐ Current Substance Use

☐ Hx of Substance Abuse

☐ Runs Away

☐ Violence/Aggression towards others

☐ Takes Dangerous Risks

☐ School Refusal

☐ Lack of Social Group

☐ Gang Involvement

☐ Med Compliance Issues

☐ Fire Setting

☐ High Risk Sexual Activity

☐ Isolates

☐ Sexualized Aggression and/or behaviors

☐ Trauma history, please explain:_____

☐ Medical/Physical Issues, please explain: _____

Caregiver Risk Factors: Please identify which caregiver: _____

☐ Current Substance Use

☐ Hx of Substance Abuse

☐ Med Compliance Issues

☐ Financial Distress

☐ Housing Instability

☐

☐ Current or History of Domestic Violence

☐ Unable or Unwilling to provide supervision

☐ Lack of Natural Supports

☐ Medical/Physical Issues, please explain: _____

☐ Other: _____

Safety Concerns for Home-Based Team to Plan for *(please circle all that apply):*

Unsafe Neighborhood

Current Domestic Violence

Violent Family Member or Person Involved with Family

Lack of Safe Parking Available

Animals (Please list below for allergies)

Suspected Illegal Substances in Home

Weapons in Home

Please describe: _____

To complete referral:

Please fax the referral to Sonia Haynes, LCSW at 914-999- 6022

* Please note: All referrals will be responded to within 1 business day