NYC Short-term Crisis Respite Center
Provider Referral Form

Overview

NYC Short-term Crisis Respite Centers support people aged 18 and over who are anticipating or experiencing a mental health crisis by providing a voluntary stay in a home-like setting which is supportive, comfortable and safe. Guests stay at the respite by personal choice and not as "forced treatment" and can come and go at their leisure without a curfew. Respites offer 24/7 support by trained Peer Specialists (individuals with lived experience of mental health conditions) as well as mental health professionals such as licensed social workers. Respites provide an innovative and unique alternative and/or complementary service to more traditional emergency room and inpatient care. Guests are provided with services including but not limited to: individual and group peer support; crisis prevention / intervention planning; referrals and linkages; health and wellness coaching; assistance with strengthening living skills; health navigation; and help with developing coping skills. Individuals referred to Respites may be enrolled the same day, pending bed availability and proper documentation. Guests may stay for up to 7 calendar days and may continue their daily activities (work, school, social enagagements) as well as meet with their treatment provider(s) and other supporters at the Respite if they wish. With the guest's consent, collaboration between Respite staff and the individual's treatment provider(s) and other supporters is welcome. Inability to pay for services does not affect eligibility.

Please note that completion of this provider referral form does not guarantee enrollment to a Respite Center

There are 8 Short-term Crisis Respite Centers in NYC in different boroughs which can be contacted directly at the following numbers:

Brooklyn – SUS: (347) 505-0870 / Fax: (877) 603-5170 **or SUS:** (646) 757-4561 / Fax: (877) 585-8837; **or OHEL:** (718) 686-3262 / Fax: (718) 686-4262
Bronx – Mosaic Mental Health: (718) 884-2992 / Fax: (718) 884-2901
Queens – TSI: (718) 464-0375 / Fax: (718) 217-2366
Manhattan – Community Access: (646) 257-5665 / Fax: (212) 614-1413 **or ACMH:** (212) 253-6377 / Fax: (212) 253-8679
Staten Island- St. Joseph: (718) 876-2810 / Fax:(718) 876-4414

Date of Referral: _____ Name of Person Being Referred: _____

DOB: _____ Contact # for Person Referred: _____

Insurance Information:
Medicaid #_____ Manage Care Organization:_____

The questions below should be answered by the potential crisis respite center guest:

1. Please indicate your reasons for seeking a stay at the Crisis Respite Center:
Click here to enter text.

2. Please indicate what you expect/hope to obtain from your stay at the Crisis Respite Center?
Click here to enter text.

_____
Print Name of Potential Guest

_____ _____
Signature of Potential Guest Date

The following eligibility and enrollment consideration questions must be answered by license cical provider.

The person being referred:

1. Is experiencing emotional/ mental health distress or crisis
   ☐Yes ☐No
2. Is a resident of New York City
   ☐Yes ☐No
3. Is 18 years or older
   ☐Yes ☐No
4. Is a voluntary enrollee (Individual must choose to participate in Crisis Respite services.)
   ☐Yes ☐No
5. Has an agreed upon place to return to upon conclusion of stay (NOTE: People who are street homeless or in a shelter may be accepted)
   ☐Yes ☐No
   Discharge location: _____
6. Is in stable physical health which includes **not** needing inpatient detoxification services
   ☐Yes ☐No
   Medical /chronic health issue (if any) _____
7. Has the ability to manage his/her own medication independently, if he/she chooses to take medications (Medications are not dispensed at Crisis Respite Centers)
   ☐Yes ☐No ☐N/A
8. The person being referred can navigate a flight of stairs
   ☐Yes ☐No
9. Person being referred has a history of violence within the last 90 days (Individuals with a history of violence within the last 90 days will still be considered on a case-by-case basis.)
   ☐Yes ☐No
10. Person being referred has a psychiatric diagnosis of serious mental illness or presents signs and symptoms that are consistent with a possible serious mental illness
    ☐Yes ☐No
    If the person has been formally diagnosed please indicate diagnosis: _____
11. How many times did the individual used CRC services this year_____Date(s) _____

The Crisis Respite Centers cannot enroll individuals with the concerns indicated below. Please confirm the person does <u>not meet</u> the below criteria:

1. The person being referred is at imminent risk of serious harm to self or others
   ☐Yes ☐No
2. Has a diagnosis of dementia, organic brain disorder or traumatic brain injury (TBI)
   ☐Yes ☐No

Referring Provider Agency Name: _____

Referring Provider Agency Program Name: _____

Print Referring Provider Staff Name: _____

Signature: _____ Licence# _____

Phone: _____ Fax: _____ Email: _____

NOTE: While not required for enrollment, any additional documents (such as psychosocial or psychiatric evaluations) may be sent with this form and are appreciated. Thank you for your referral.