New York City's Residential Crisis Support/Respite Referral Form

These short-term voluntary programs provide a supportive and home-like environment for individuals experiencing a mental health crisis.They can also help to reintegrate a person into the community after inpatient care. Guests can stay from 1 day up to 28 days based on need and will have 24/7 access to staff support. These programs are not an alternative to permanent housing or shelter. Programs are appropriate for individuals who are not at imminent risk to the safety of themselves or others. Call 1-888-NYC-WELL (1-888-692-9355) or any of the NYC Residential Crisis Support/Respite programs listed below for referral information.

Agency (Program Name)	Beds Per Site	Borough	Phone Number	Fax Number
Mosaic Mental Health	10	Bronx	(718) 884-2992	(718) 884-2901
S:US (Brooklyn Respite)	10	Brooklyn	(347) 505-0870	(877) 603-5170
S:US (Bright Corner)	3	Brooklyn	(646) 757-4561	(877) 603-5170
OHEL	2 1	Brooklyn	(800) 603-6435	(718) 686-4250
Community Access	8	Manhattan	(646) 257-5665 Ext. 8401	(212) 614-1413
ACMH (Garden or Independence House)	3 7	Manhattan	(212) 253-6377 Ext. 406/408	(212) 253-8679
WellLife	3	Queens	(718) 309-7486	(347) 542-5847
Transitional Services for NY (Miele's Respite)	10	Queens	(718) 464-0375	(718) 217-2366
St. Joseph's Medical Center	3	Staten Island	(718) 876-2810	(718) 876-4414

NOTE: Completion of this referral form does not guarantee admission. Each admission is determined on an individual basis and is based on bed availability. **This form should be completed with the voluntary consent of the individual being referred.**

Referral Date (MM/DD/YYYY)**:**_____

Referral Type:

☐Self-Referral ☐ Family/Friend ☐Outpatient MH/BH ☐Managed Care Plan ☐Inpatient MH/BH ☐CPEP ☐Emergency Department ☐Care Coordination ☐Housing ☐ Department of Homeless Services (DHS) ☐Shelter ☐Assertive Community Treatment (ACT) ☐Mobile Crisis Team ☐Safe Options Support (SOS) Team ☐Crisis line (NYCWell/988) ☐Other:

Potential Guest:

Preferred Name (Print): _____ Legal Name (First, Last)_____

Date of Birth: _____ 18 years or older: ☐Yes ☐No

Address/Location: _____ NYC Resident: ☐Yes ☐No

Preferred Language/s: ☐ English ☐Spanish ☐ Other:_____

Insurance Provider (if available): _____Insurance Policy ID#/CIN#: _____

Potential Guest Phone# 1: _____ Phone# 2: _____

Can Receive Voicemail:☐Yes ☐No

Email:_____

Emergency Contact's Name (if available):_____Relationship: _____

Emergency Contact Phone# 1: _____ Phone# 2: _____

Description of Current Crisis:

1. How may this short-term crisis support program help? (Select all that apply)
   ☐ Help with making a wellness and recovery plan ☐ Receive peer support ☐Prevent hospitalization
   ☐Transition from inpatient to the community ☐Other:_____
2. Is experiencing a mental health crisis and/or challenges that are contributing to mental health symptoms that cannot be managed well in the person's home or current environment? ☐Yes ☐No
3. Has an Assisted Outpatient Treatment (AOT) order? ☐Yes ☐No
4. Is medically stable? ☐Yes ☐No
5. Has significant medical conditions/allergies? ☐Yes ☐No ☐Prefer Not to Answer

List Significant Medical Conditions/Allergies:

6. Can take care of personal needs and self-preserve (ex. eating, using the restroom, taking prescribed medications) without assistance? ☐Yes ☐No
7. Needs onsite accommodations (ex. wheelchair accessible site, assistance with stairs)? ☐Yes ☐No

Accommodations Needed:

8. Has a safe and stable place to return to after stay and/or is willing to go to a shelter if needed? (**NOTE**: homelessness or housing insecurity is not an exclusion criteria): ☐Yes ☐No ☐Unsure

Expected Discharge Address/Location (if known): _____

Referring Provider/Referral Contact (Skip to Potential Guest's Signature if this is a self-referral)**:**

Referral Contact's Name: _____ Relationship to Potential Guest: _____

Referral Contact's Phone #1: _____ Phone# 2: _____

Email: _____Fax:_____

Referral Agency Name (if applicable): _____

Licensed Credential (LCSW, LMHC, MD, if applicable): _____

_____

Referring Provider/Referral Contact's Signature **Date**

_____

Potential Guest's Signature **Date**

Thank you for your referral.

Staff Use Only

Form Received Date:_____ Time: _____

Reviewed By (Print Name):_____

Program Supervisor Signature:_____

Initial Contact with Guest (Print Name): _____ Date:_____ Time:_____

Expected Arrival Date: _____ Expected Arrival Time:_____

Declined Services: ☐Yes ☐No

Reason:_____

Notes:

_____
_____
_____
_____
_____