



Residential Crisis Support *Referral Form*

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	(212) 614-1413
ACMH (Garden or Independence House)	3	Manhattan	(212) 253-6377 Ext. 406/408	(212) 253-8679
	7			
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

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 (988 LifeLine) Other: _____

Applicant's Chosen Name: _____		Date: _____ / _____ / _____	
Legal Name (First, MI, Last):		Pronouns:	
Phone #:		DOB:	
Email:		Social Security #:	
Current Address:			
<input type="checkbox"/> with family/friends <input type="checkbox"/> supportive housing <input type="checkbox"/> independent housing <input type="checkbox"/> shelter <input type="checkbox"/> street homeless <input type="checkbox"/> other: _____			
Emergency Contact			
Name: _____		Phone #: _____	Relationship: _____
Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____			

Entitlements <i>check here if none apply</i> <input type="checkbox"/>	
Medicaid #:	_____
Managed Care Organization & ID #:	_____
Medicare #:	_____
Other Insurance & ID #:	_____

Psychiatric Diagnosis	Medical Diagnoses / Allergies / Dietary Preferences
Primary: _____	_____
Secondary: _____	_____
Tertiary: _____	_____

Name of Applicant: _____

To be completed by the applicant:

1. In your own words, please describe your reasons for seeking a stay at the respite center.
2. Please indicate what you hope to gain from your stay at the respite center. How can staff collaborate with you towards these goals? Please be as specific as possible.
3. Signing below indicates you understand respite stays are up to 14 days. You may apply for a maximum of 14 additional days. The stay will not exceed 28 days. If there are any concerns around this, please describe below.

_____ / _____ / _____

Print Name of Applicant

Signature of Applicant

Date

To be completed by a licensed provider:

The person being referred:

1. is experiencing an emotional/mental health crisis Yes No
2. is not at imminent risk of serious harm to self or others Yes No
3. can take care of self (eating, using the restroom, ADL's) without assistance/supervision Yes No
4. Can navigate stairs Yes No
5. Has a discharge address/location: _____

**People who are street homeless/returning to a shelter qualify for respite. Respite staff are not responsible for placement/housing/post-discharge planning.*

Signing below affirms your knowledge that the person being referred:

Referring Provider Name: _____

Organization/Program Name: _____

Phone #: _____ ext.: _____

Alternative Phone #: _____ License # & type: _____

Email: _____

Signature: _____

COMMUNITY ACCESS INDIVIDUAL AUTHORIZATION FORM- HIPAA

Name	Date of Birth	CA Program (if applicable):
Address		

I, or my authorized representative, request that health information regarding my care and treatment as set forth on this form: In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol, or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE PROVIDER OR ENTITY SPECIFIED IN ITEM 9.**

7. Please select one of the following: <ul style="list-style-type: none"> • Disclosure of Health Information (CA to another entity, person or Provider) • Disclosure of Health Information (other entity/provider to CA) • This is a records request (e.g., CA staff requesting hospital/ provider records) 	
8. Name and address of health provider or entity to release this information:	
9. Name and address of health provider or entity to whom this information will be sent:	
10. Purpose for Release of Information:	
11. Specific information to be released: <ul style="list-style-type: none"> ○ Medical Record form (insert date)_____ to (insert date)_____ ○ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers. ○ Other: _____ Include: <i>(Indicate by Initialing)</i> <ul style="list-style-type: none"> _____ Alcohol/Drug Treatment _____ Mental Health Information _____ HIV-Related Information 	
12. Reason for release of information: <ul style="list-style-type: none"> ○ At request of individual ○ Other: _____ 	13. Date or event on which this authorization will expire:
14. If not the patient, name of person signing form:	15. Authority to sign on behalf of patient:

All Items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

Signature of Patient or representative authorized by law.

Date

* Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.