

Adult Behavioral Health Home & Community Based Services and CORE Referral Form

Date of Referral: _____

Referring Person	First Name		Last Name	
	Agency Name		Phone #	
	Address		E-mail	
HH Care Mgr/ Service Coordinator Information	First Name		Last Name	
	Agency Name		Phone #	
	Address		E-mail	
HCBS Participant Information	First Name		Last Name	
	Soc. Sec. #		Address	
	Phone #		Alt. Phone #	
	E-mail		Date of Birth	
	Prim. Language			
HCBS Participant Health Care Information	MCO Name		Policy ID #	
	MCO Contact Name		MCO Telephone Number	
	MCO Contact E-mail		Medicaid CIN Number	
	Prim. Diagnosis & ICD 10 Code		Secondary Diagnosis & ICD 10 Code	
Any Known Safety Concerns? (Criminal Record, History of Violence, Weapons in the Home, Sex Offender, Bed Bugs, etc.):				N/A

<u>HCBS Service(s):</u>	<u>CORE Service(s):</u>
Habilitation	Psychosocial Rehabilitation
Pre-Vocational Services	Empowerment Services (Peer Support)
Ongoing Supported Employment	PSR w/Education
Intensive Supported Employment	PSR w/ Employment
Education Support	Family Support and Training
Any Identified Service Restrictions Surrounding Client Availability? N/A	

AGENCY INFORMATION

AGENCY NAME: _____ **POINT OF CONTACT:** _____
PHONE: _____ **FAX:** _____ **EMAIL:** _____

Programs and Services:
 87 North Clinton, Rochester, NY 14604-1458 | 1099 Jay Street, Bldg J, Rochester, NY 14611
 585.546.7220 585.339.9800

Regional Office:
 2462 State Rt. 54A, Ste. 209, Penn Yan, NY 14527
 315.536.2370