

**MHA Office Use Only:**

Date Received by: Date Logged In by: Date Approved by: Date Referred Out:

320 North Goodman St. Rochester, NY 14607

Office: 585-325-3145 x 152

Email: [mhafssreferral@mharochester.org](mailto:mhafssreferral@mharochester.org)

**Client ID:**

**CLIENT INFORMATION:**

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First Name: Mid. Init:

Last Name:

Current Street Address:

D.O.B.

Policy #/CIN:

City:

State:

Zip Code:

Mobile Phone: Work phone: Home Phone:

Residence Type (private, group home, etc.)

E-mail address:

Default Communication Method:

* Home email
* Home phone
* Mail
* Mobile phone call
* Mobile phone text
* Work email
* Work phone

Gender:

* Female
* Male
* Other

Race: Ethnicity:

* White  Hispanic
* Black/African American  Non-Hispanic
* Native American
* Asian/Pacific Islander
* Hispanic
* Biracial
* Other

Additional Race:

* White
* Black/African American
* Native American
* Asian/Pacific Islander
* Hispanic
* Biracial
* Other

Primary Language:

* English only
* American Sign Language (ASL)
* Portuguese
* Spanish only
* Bi Lingual
* Other

Interpretation/Translation Needs:

* Yes
* No
* Parent can interpret English writing
* Parent can interpret Spanish writing Other

**REFERRAL DATE:**

MHA Rochester Referral for Children and Family Treatment and Support Services

(CFTSS)



**CHILD INSURANCE INFORMATION (1):**

**CHILD INSURANCE INFORMATION (2):**

**PARENT OR GUARDIAN CONTACT:**

**CHILDS INFORMATION (1):**

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Primary Diagnosis **(ICD-10)**:

Environmental Stressors:

Secondary Diagnosis **(ICD-10)**:

Functional impairment:

Medical Conditions:

SPMI? Yes No

Symptomatic Behaviors:

Does client have any physical limitations? Yes No If yes, please describe

Does client take medication(s)? Yes No Please list:

Are there any side effects we should be aware of?

Current involvement in treatment and programs (e.g. therapy, day-treatment, volunteering, and recreation) - please list:

Name:

Relationship to Client:

Date of Birth:

Transportation: Yes No

Phone (Day):

Address:

Phone (Evening):

City:

Zip:

Does the parent/caregiver have access to transportation? Yes No What type? Car Bus

Other

Are there any special needs for transportation? If yes, please explain (i.e. wheelchair access, etc.):

Insurance ID No.:

Date Insurance Effective:

Insurance Provider/MCO:

Insurance ID No.:

Date Insurance Effective:

Insurance Provider/MCO:

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**CHILDS INFORMATION (2):**

**REFERRING AGENCY CONTACT INFORMATION**

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**Other Provider:**

Title:

Agency:

Address:

City:

Zip:

Phone

**(Required):**

Fax:

Email

**(Required):**

**Health Home Care Coordinator:**

Title:

Agency:

Address:

City:

Zip:

Phone

**(Required):**

Fax:

Email

**(Required):**

Preferred Method of Contact:

E-mail Mail

Relationship/role with client:

Type of treatment:

**Other Provider:**

Title:

Agency:

Address:

City:

Zip:

Phone

**(Required):**

Fax:

Email

**(Required):**

**Referring Provider:**

Title:

Agency:

Address:

City:

Zip:

Phone

**(Required):**

Fax:

Email

**(Required)**:

Preferred Method of Contact:

E-mail Mail

Relationship/role with client:

Type of treatment:

Primary Diagnosis **(ICD-10)**:

Environmental Stressors:

Secondary Diagnosis **(ICD-10)**:

Functional impairment:

Medical Conditions:

SPMI? Yes No

Symptomatic Behaviors:

Does client have any physical limitations? Yes No If yes, please describe

Does client take

medication(s)? Please List them:

Yes No

Are there any side effects we should be aware of?

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**Additional comments: (please describe how the services are necessary)**

* Engagement, Bridging, and Transition Support
* Self-Advocacy, Self-Efficacy and Empowerment
* Parent Skill Development
* Community Connections and Natural Supports
* Education Advocacy
* Support Groups
* Family Education Workshops

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* Skill Building
* Coaching
* Self-Advocacy, Self-Efficacy and Empowerment
* Community Connections and Natural Supports
* Engagement, Bridging and Transition Support

**Family Peer Support Services**

**Youth Peer Support Services:**

**Recommended Family Support Service(s):** *Check all that apply:*

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**Rehabilitative Service**

**Description of needed intervention**

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