Client Referral Form

Fax completed form to Central Scheduling at 914-347-8859

MHA The Mental Health Association of Westchester

Are you a returning client?	☐ Yes ☐ No	**Today's Date**	/ /	**Preferred Name**	
Last Name		**First Name**		**Sex on Insurance**	☐ Female ☐ Male
Gender Identity	☐ Female ☐ Transgender Woman/Female ☐ Male ☐ Transgender Man/Male ☐ Other ☐ Choose Not To Disclose	**Sexual Orientation**	☐ Bisexual ☐ Choose Not To Disclose ☐ Does Not Know ☐ Lesbian, Gay, or Homosexual ☐ Other ☐ Straight or Heterosexual		
Date of Birth	/ / Month Day Year	**Social Security #**	– –		

Your answers to the following questions will help us reach you quickly and discreetly with important information.

Address	Street	City	State Zip Code
Type of Residence	☐ Private Residence ☐ DSS/ACS Agency Boarding/Foster Home ☐ Homeless (Shelter/Street/Transitional Living Center)	☐ Incarcerated ☐ Nursing Home or Health-Related Facility ☐ Other: _____	
Mobile Phone	( ) –	☐ OK to Leave Message – Mobile Phone	
Other Phone	( ) –	☐ OK to Leave Message – Other Phone	
Email Address		☐ Email is Shared	
Preferred Contact Method (Please choose 1)	☐ Mobile Phone ☐ Other Phone ☐ Email ☐ Text		

This information is for demographic purposes only and will not affect your care.

Race	☐ White ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Other Race ☐ Decline To Provide Race	**Ethnicity**	☐ Hispanic or Latino ☐ Decline to Provide Ethnicity ☐ Not Hispanic of Latino
		Ethnicity Detail	☐ Cuban ☐ Mexican/Mexican American/Chicano(a) ☐ Dominican ☐ Other Hispanic ☐ Ecuadorian ☐ Puerto Rican
Preferred Language		**Secondary Language**	
Special Communication Needs	☐ None Reported ☐ Language Interpreter Services ☐ Other ☐ TDD/TTY Device ☐ Sign Language Interpreter Describe: _____		
Special Physical Accommodations (If yes, please describe)			

Veteran	☐ Yes ☐ No	**Active Duty**	☐ Yes ☐ No	**Discharge Status**	☐ Dishonorable ☐ Honorable ☐ General ☐ N/A	**Other**	☐ Disabled Veteran ☐ VA Services Eligible ☐ Veteran Family Member

Do you have insurance?	☐ Yes ☐ No	**Relationship to Insured**	
Insurance		**ID/Policy #**	
		Medicaid # (if applicable)	
Additional Insurance		**ID/Policy #**	
		Medicaid # (if applicable)	

If different from client, please provide the information below.

Insured Name			
Date of Birth	/ / Month Day Year	**Social Security #**	– –

Emergency Contact		**Phone #**	( ) –
Relationship		**Preferred Language (if other than English)**	
Address	Street	City	State Zip Code

If client is a minor, please provide the information below.			
Parent/Guardian Name		**Phone #**	( ) –
Address	Street	City	State Zip Code
Preferred Language (if other than English)		**Relationship**	

Referral Source (Organization)		**Referral Contact (Person)**	
Primary Reason for Referral		**Initial Contact Method (How did you hear about us?)**	
Referral Source Address			
Referral Contact Phone #	( ) –	**Email**	

If applicable, please fill out the hospital referral information below.			
Recently Hospitalized	☐ Yes ☐ No	**COPS Referral (Hospital Inpatient)**	☐ Yes ☐ No
Hospital		**Discharge Date**	/ /
Discharge Paperwork Sent	☐ Yes ☐ No *If no, when will it be sent:* _____		
Receiving Injectable Medication	☐ Yes ☐ No	**If Yes, Next Due Date**	/ /
Injectable Medication/Dosage			
On Clozaril	☐ Yes ☐ No	**If Yes, Next Blood Draw**	/ /

Please check all that apply.

☐ Criminal History
☐ Parole/Probation
☐ Sex Offender
☐ History of Aggression
☐ Suicide Risk
☐ AOT
☐ Eating Disorder
☐ Medication Assisted Treatment
☐ ACT
☐ Recent Discharge from Psych or SUD Treatment
☐ Chronic Health Conditions: _____
☐ Co-Occurring Disorder: _____
☐ History or Current SUD: _____

Please select a service location.

☐ **White Plains**
29 Sterling Ave
White Plains, NY 10606

☐ **Mt Kisco**
344 Main Street- Suite 301
Mt Kisco, NY 10549

☐ **Yonkers**
20 South Broadway- Suite 402
Yonkers, NY 10701

☐ **Upper Nyack**
311 N. Midland Ave- Suite #3
Nyack, NY 10960

☐ **Haverstraw**
20 George Street
Haverstraw, NY 10927

☐ **IOP**
29 Sterling Ave
White Plains, NY 10606

☐ **Caremount – Mt Kisco**
110 S Bedford Rd
Mt Kisco, NY 10549

☐ **OnTrack NY**
20 South Broadway- Suite 402
Yonkers, NY 10701

☐ **Nyack – BOCES**
131 Midland Avenue
North Nyack, NY 10960

For school referrals only

☐ **Fieldstone Middle School**
100 Fieldstone Drive, Thiells, NY 10984

☐ **North Rockland High School**
106 Hammond Road, Thiells, NY 10984

☐ **NR High School Extension**
63 Chapel Street, Garnerville, NY 10923

Please select services you are interested in. If you are enrolled in any of the services below please identify your care manager.

☐ Care Management/Manager: _____
☐ HCBS Services: _____
☐ SUD/Credentialed Alcoholism & Substance Abuse Counselor (CASAC)/Encompass: _____
☐ Peer Outreach: _____
☐ Family Support: _____
☐ Employment Services: _____

To be filled out by MHA Staff.			
Program		**Client ID**	
Assigned Clinician		**Self-Pay Assigned**	

Please fax form to (914)347-8859 attention Central Scheduler. Intakes are processed within 24-48 hours of receipt. Due to high call volume we will relay the appointment information to you as soon as possible via phone. Please provide that information where indicated. If this form is incomplete scheduling can be delayed.