MHA Rochester
Referral for Children and Family Treatment and Support Services (CFTSS)

274 North Goodman St.
Rochester, NY 14607
Office: 585-325-3145 x602
Email: mhafssreferral@mharochester.org

MHA Office Use Only:
Date Received by: _____
Date Logged In by: _____
Date Approved by: _____
Date Referred Out: _____

Client ID: _____

REFERRAL DATE:

CLIENT INFORMATION:

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: ☐ White ☐ Black/African American ☐ Native American ☐ Asian/Pacific Islander ☐ Hispanic ☐ Biracial ☐ Other Ethnicity: ☐ Hispanic ☐ Non-Hispanic	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		

MENTAL HEALTH ASSOCIATION
FIND WELLNESS.

MHA Rochester
Referral for Children and Family Treatment and Support Services (CFTSS)

CHILD INSURANCE INFORMATION (1):

Insurance ID No.:	Date Insurance Effective:
Insurance Provider/MCO:	

CHILD INSURANCE INFORMATION (2):

Insurance ID No.:	Date Insurance Effective:
Insurance Provider/MCO:	

PARENT OR GUARDIAN CONTACT:

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.):

CHILDS INFORMATION (1):

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:

MENTAL HEALTH ASSOCIATION
FIND WELLNESS.

MHA Rochester
Referral for Children and Family Treatment and Support Services (CFTSS)

CHILDS INFORMATION (2):

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?	

REFERRING AGENCY CONTACT INFORMATION

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:	

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):**	

Other Provider:		Title:	
Agency:			
Address:		City:	Zip:
Phone **(Required):**	Fax:	Email **(Required):**	

MHA Rochester
Referral for Children and Family Treatment and Support Services (CFTSS)

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

Rehabilitative Service	Description of needed intervention
Family Peer Support Services	☐ 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
Youth Peer Support Services:	--- ☐ Skill Building ☐ Coaching ☐ Self-Advocacy, Self-Efficacy and Empowerment ☐ Community Connections and Natural Supports ☐ Engagement, Bridging and Transition Support
Additional comments: (please describe how the services are necessary)	