



MHA
ROCHESTER

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

274 North Goodman St., Suite D103

MHA Office Use Only

Rochester, NY 14607

Date Received: _____

Office Phone: (585)325-3145

Date Logged: _____

Email: mhafssreferral@mharochester.org

Date Approved: _____

Date Referred: _____

Client ID: _____ Referral Date: _____

CLIENT INFORMATION

First Name: _____ Last Name: _____ Middle Initial: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Residence Type (private, group home, etc.): _____

Date of Birth (DOB): _____ Policy #/CIN: _____ Mobile #: _____

Work #: _____ Home #: _____ Email: _____

Preferred Communication Method (i.e. Home phone, work phone, email, mail, etc): _____

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

Ethnicity: Hispanic Non-Hispanic Gender: Male Female 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 Bilingual

Interpretation/Translation Needs: Yes No

Parent Can Interpret English Writing Parent Can Interpret Spanish Writing Other: _____

CHILD INSURANCE INFORMATION (1)

Insurance ID #: _____ Date Insurance Effective: _____

Insurance Provider: _____

CHILD INSURANCE INFORMATION (2)

Insurance ID #: _____ Date Insurance Effective: _____

Insurance Provider: _____



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PARENT OR GUARDIAN CONTACT INFORMATION

Name: _____ Relationship to Client: _____

DOB: _____ Phone (Day): _____ Phone (Evening): _____

Address: _____ City: _____ State: _____ Zip: _____

Transportation (circle response)

Does the caregiver have access to transportation? Yes No Type: Car Bus Other: _____

Are there any special needs for transportation? Yes No If yes, explain: _____

CHILD (1) INFORMATION

Primary Diagnosis (ICD-10): _____ Secondary Diagnosis (ICD-10): _____

SPMI: Yes No Medical Conditions: _____

Does client have any physical limitations? Yes No

If yes, describe: _____

Does client take medications? Yes No

If yes, list: _____

Are there any side effects we should be aware of? (if yes, describe)

Current Involvement in treatment & programs (ie. therapy, day treatment, volunteering, and recreation):

CHILD (2) INFORMATION

Primary Diagnosis (ICD-10): _____ Secondary Diagnosis (ICD-10): _____

SPMI: Yes No Medical Conditions: _____

Does client have any physical limitations? Yes No

If yes, describe: _____

Does client take medications? Yes No

If yes, list: _____

Are there any side effects we should be aware of? (if yes, describe)

Current Involvement in treatment & programs (ie. therapy, day treatment, volunteering, and recreation):

REFERRING AGENCY CONTACT INFORMATION

Referring Provider: _____	Title: _____
Agency: _____	
Address: _____	City: _____ State: _____ Zip: _____
Phone (required): _____	Fax: _____ Email (required): _____
Preferred Method of Contact Phone <input type="checkbox"/> Email <input type="checkbox"/> Relationship/role with client: _____	
Type of Treatment: _____	

Health Home Care Coordinator: _____	Title: _____
Agency: _____	
Address: _____	City: _____ State: _____ Zip: _____
Phone (required): _____	Fax: _____ Email (required): _____
Preferred Method of Contact Phone <input type="checkbox"/> Email <input type="checkbox"/> Relationship/role with client: _____	
Type of Treatment: _____	
Other Provider: _____	Title: _____
Agency: _____	
Address: _____	City: _____ State: _____ Zip: _____
Phone (required): _____	Fax: _____ Email (required): _____
Preferred Method of Contact Phone <input type="checkbox"/> Email <input type="checkbox"/> Relationship/role with client: _____	
Type of Treatment: _____	

Other Provider: _____	Title: _____
Agency: _____	
Address: _____	City: _____ State: _____ Zip: _____
Phone (required): _____	Fax: _____ Email (required): _____
Preferred Method of Contact Phone <input type="checkbox"/> Email <input type="checkbox"/> Relationship/role with client: _____	
Type of Treatment: _____	

<p>Recommended Family Peer Support Service(s) <i>Check all that apply</i></p> <p>Engagement, Bridging, & Transition Support <input type="checkbox"/></p> <p>Self-Advocacy, Self-Efficacy & Empowerment <input type="checkbox"/></p> <p>Parent Skill Development <input type="checkbox"/></p> <p>Community Connections & Natural Supports <input type="checkbox"/></p> <p>Education Advocacy <input type="checkbox"/></p> <p>Support Groups <input type="checkbox"/></p> <p>Family Education Workshops <input type="checkbox"/></p>	<p>Recommended Youth Peer Support Service(s) <i>Check all that apply</i></p> <p>Skill Building <input type="checkbox"/></p> <p>Coaching <input type="checkbox"/></p> <p>Self-Advocacy, Self-Efficacy, & Empowerment <input type="checkbox"/></p> <p>Community Connections & Natural Supports <input type="checkbox"/></p> <p>Engagement, Bridging, & Transition Support <input type="checkbox"/></p>
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<p>Additional Comments (please describe how the services are necessary):</p> <p>_____</p> <p>_____</p>
