Catholic Charities
Steuben/Livingston
*Stronger Together*

# Children's CFTSS/HCBS Referral Form

| | | |
|---|---|---|
| **Name:** | **DOB:** | **Gender:** ☐ Male ☐ Female |
| **Ethnicity:** ☐ Hispanic ☐ Non-Hispanic<br>**Race:**<br>(eg. Caucasian, African American, Amer. Indian, Multi-Racial, etc.)<br>**Primary Language:** | **Date of Referral:**<br><br>**Referring Agency:** | **Referral Contact Name:**<br><br>**Phone:** |
| **Address:**<br>**Phone:** | | **County:** |
| **Name of Legal Guardian:**<br>**Phone:**<br>**Address** (if different): | **DOB:** | **Relationship to Youth:** |
| **Where does Youth Reside:** ☐ Parent/Guardian Home: Biological ☐ Parent/Guardian Home: Adoptive ☐ Grandparent Home ☐ Other (please describe): | | |
| **Medicaid CIN#:**<br>**Medicaid Social Security Income (SSI):** ☐ Yes ☐ No ☐ Unknown | **Managed Care Organization** (Excellus, Fidelis, MVP, etc.):<br><br>**Subscriber ID** (if known): | |
| **Primary Reason for Referral / Safety Concerns / Behavioral Concerns / Other Comments:** | | |
| **Primary Diagnosis:**<br><br>**Additional Diagnosis:** | **Primary Diagnosis Axis Code:**<br><br>**Diagnosed By:** | **Date Diagnosed:** |
| **Does youth have a current Therapist/Clinician:** ☐ Yes ☐ No<br>If YES, Name, Agency, and Contact Information: | | |
| **For CFTSS – Medical Necessity Recommendation (MNR) completed by:**<br>Please attach completed Medical Necessity Recommendation to this form. | | |

| **CFTSS Services Desired** | **Reason for Service / Special considerations / Additional Helpful Information** |
|---|---|
| **Other Licensed Practitioner (OLP):** ☐ Yes ☐ No | **Not Yet Available** |
| **Community Psychiatric Supports & Treatment (CPST):** ☐ Yes ☐ No | **Not Yet Available** |
| **Psychosocial Rehabilitation (PSR):** ☐ Yes ☐ No | |

| **HCBS Services Desired**<br>Please submit Level of Care (LOC) along with this referral | **Reason for Service / Special considerations / Additional Helpful Information** |
|---|---|
| **Caregiver/Family Support Services:** ☐ Yes ☐ No | |
| **Community Self Advocacy Supports and Services:** ☐ Yes ☐ No | |
| **Prevocational Services:** ☐ Yes ☐ No | |
| **Supported Employment:** ☐ Yes ☐ No | |
| **Crisis Respite** (Day only): ☐ Yes ☐ No | **Not Yet Available** |
| **Planned Respite** (Day only): ☐ Yes ☐ No | |

**Please submit all referral documentation by secure email to: Michelle.dourie@dor.org (585) 658-4466 ext. 16 Fax (585) 658-2513**