Referral for Children & Family Treatment & Support Services

Instructions: This form can only be completed and signed by a Licensed Practitioner of the Healing Arts (LPHA). (Individual currently licensed as a Registered Professional Nurse, Nurse Practitioner, Psychiatrist, Licensed Psychologist, Licensed Psychoanalyst, Licensed Master Social Worker, Licensed Clinical Social Worker, Licensed Marriage & Family Therapist, Licensed Mental Health Counselor, Licensed Creative Arts Therapist or Physician).

Participant Name:	Date of Birth:
Parent/Caregiver:	Relationship:
Address:	Phone:
County:	Medicaid CIN #:
Referral Source Name/Agency/Title:	Referral Source Contact #:

Behavioral Health Information (A mental illness/substance abuse diagnosis is required for a recommendation of PSR).

	Diagnosis Category	Specific Diagnosis or Symptoms of Mental Illness/ Substance Abuse	ICD 10 Code
Primary			
Secondary			
Other			

Areas of Functioning (As a result of the symptoms or diagnosis of mental illness/substance abuse, the youth has functional impairment that interferes with or limited functioning in at least one of the following areas and is likely to benefit from and respond to the service(s) recommended to prevent the onset or worsening of symptoms). Check all that apply.

Check	Domain	Description of Impairment
	Self-direction/Control	
	Self-care	
	Family Life	
	Social Relationships	
	Symptom Management	

Recommended Services Check all that apply. More services to be added in the future.

Check	Rehabilitative Service	Description of Needed Intervention (if known)
	Psychosocial Rehabilitation (PSR)	

Reason for Recommendation:

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Service Linkage & History

Provider Type	Provider Name/Agency	Current/Past
Outpatient Clinic		
Psychiatry		
Health Home Care Coordinator		
Social Services		
OPWDD		
Other:		
Other:		

***Please attach Plan of Care/Life Plan written by Care Coordinator to this referral (if available).**

By signing below, I am recommending the above-named individual for Children & Family Treatment & Support Services.

______________________	______________________	______________
LPHA Signature	**LPHA Printed Name**	**Date**
______________________	______________	______________
LPHA Credentials	**NPI #**	**License #**

Please submit all referrals to:

Central Intake & Admissions, 30 Wilson Road, Williamsville, NY 14221
Intake@ArcErieCounty.org
Questions?: 1-833-Arc-Erie

<u>For Intake Use Only</u>

Date Received: __________ **Intake Staff Initials:** __________ **SS Tracking #:** __________

EHR/Records: __________ **Life Plan Obtained/Attached:** __________ **MCO:** ____________________