REFERRAL FOR FAMILY PEER SUPPORT SERVICES

Please send completed forms securely to referrals@famtieswest.org or fax to (914) 995-8421

REFERRAL SOURCE'S INFORMATION		
Referral Date:	**Name:**	
Organization:	**Phone #:**	**Email:**

REASON FOR REFERRAL

Type of Referral ***(please check all that apply)***		
☐ Individual/Group Support and Advocacy	☐ Parent Skills Coaching	☐ Wraparound

≠ To make a referral for CFTSS or HCBS, please email referrals@famtieswest.or or call (914) 995-5238. ≠

CAREGIVER #1 INFORMATION		
Name:	**Preferred Name:**	
Address:		
Phone #:	**Email:**	
Preferred Method & Time of Contact:		
Preferred Time to Work with a Family Peer Advocate:		
DOB:	**Gender Identity:**	**Preferred Pronouns:**
Insurance Type: ☐ **Medicaid/Medicare** ☐ **Private** ☐ **None**		**Provider:**
Race:	**Ethnicity:**	**Preferred Language:**
Relationship to Youth/Young Adult:	**Does Caregiver have legal custody?** ☐ Yes ☐ No ☐ Unknown **If no, who has legal custody?**	

CAREGIVER #2 INFORMATION ***(if applicable)***		
Name:	**Preferred Name:**	
Address:		
Phone #:	**Email:**	
Preferred Method & Time of Contact:		
Preferred Time to Work with a Family Peer Advocate:		
DOB:	**Gender Identity:**	**Preferred Pronouns:**
Insurance Type: ☐ **Medicaid/Medicare** ☐ **Private** ☐ **None**		**Provider:**
Race:	**Ethnicity:**	**Preferred Language:**
Relationship to Youth/Young Adult:	**Does Caregiver have legal custody?** ☐ Yes ☐ No ☐ Unknown **If no, who has legal custody?**	

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YOUTH/YOUNG ADULT'S INFORMATION			
Name:		**Preferred Name:**	
Does the youth/young adult currently reside with the caregiver(s)? ☐ Yes ☐ No ☐ Unknown **If no, what is their current address:**			
DOB:	**Gender Identity:**	**Preferred Pronouns:**	
School/District:	**Grade:**	**Does the youth/young adult have an IEP?** ☐ Yes ☐ No ☐ Unknown **Does the youth/young adult have a 504 plan?** ☐ Yes ☐ No ☐ Unknown	
Does the youth/young adult have a mental health diagnosis? ☐ Yes ☐ No ☐ Unknown **If yes, please specify:**			
Does the youth/young adult have a history of hospitalization? ☐ Yes ☐ No ☐ Unknown **If yes, please describe:**			
Has the youth ever been placed outside of the home? ☐ Yes ☐ No ☐ Unknown **If yes, when and where?**			
Insurance Type: ☐ Medicaid/Medicare ☐ Private ☐ None		**Provider:**	
Race:	**Ethnicity:**	**Preferred Language:**	

Is the family in receipt of any of the following Family Assistance Services?			
☐ Full FA/SN	☐ HEAP	☐ SNAP	☐ Unknown

ADDITIONAL INFORMATION		COMMENTS
Any history of out of home placements for other children in the family?	☐ Yes ☐ No ☐ Unknown	
Any history of preventive services for the family?	☐ Yes ☐ No ☐ Unknown	
Are there any current orders of protection?	☐ Yes ☐ No ☐ Unknown	
Any history of serious trauma we should be aware of?	☐ Yes ☐ No ☐ Unknown	

IS THE FAMILY CURRENTLY WORKING WITH OTHER PROVIDERS? ***(please list service, provider and their contact information)***

We believe that everyone deserves the opportunity to reach their full potential and contribute to their community. Family Ties promotes the well-being of families raising children with social and emotional challenges through lived experience and on-the-ground expertise. We partner with families and communities across Westchester County to make sure that everyone has the foundation they need to build a healthy, meaningful life. With access to the right resources and support, every family is able to thrive. All of our services are free, confidential and voluntary.

Referrals will only be accepted with the family's consent.

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CONSENT FOR OUTREACH AND SERVICES

I hereby authorize the release of the above information concerning my child and family. I understand that the information to be released is confidential and protected from disclosure. I understand that I have the right to cancel my permission to release information any time before it is released. I also understand that my consent to release information will expire six months from the date signed. Information is released to ***FAMILY TIES*** *in order for* ***FAMILY TIES*** *to provide outreach and services to the family.*

CONSENT TO SHARE CONFIDENTIAL INFORMATION

I hereby authorize the sharing of information between ***Family Ties of Westchester, Inc.*** *and _____ to help with the planning of coordinated comprehensive services for my child and family. I understand that the information to be shared is confidential and protected from disclosure. I understand that I have the right to cancel my permission to release information any time before it is released. I also understand that my consent to release information will expire when acted upon*

Caregiver/Young Adult's Signature **Date**

Referrer's Signature **Date**

RECIPIENT RIGHTS

1. **You have the right to revoke this authorization at any time by completing "Revocation of Authorization" below. Any information released before the date of revocation will not be retrieved.**
2. **Your treatment is not dependent on you signing this authorization, except if you are seeing us solely for the purpose of creating PHI for the person/organization listed on the front of this form (ex. DSS).**
3. **If this authorization is for us to send out information, we cannot guarantee that the information will not be redisclosed. This redisclosure may not be protected under the HIPAA Privacy Rule.**
4. **You have the right to receive a copy of this authorization.**

REVOCATION OF AUTHORIZATION

☐ I hereby cancel my permission for Family Ties of Westchester, Inc. to share information from the records of _____ to the person or organization whose name and address is on this form as the referrer.

Caregiver's Signature **Date**

Witness' Signature **Date**