Rockland County
Ed Day, Rockland County Executive

CHILDREN AND FAMILY TREATMENT AND SUPPORT SERVICES (CFTSS)

REFERRAL FORM

Individual's Name:_____ **DOB:** _____

Preferred Language for Youth:_____

Medicaid (CIN) #: _____ **Insurance Policy #:**_____

Caregiver Name(s): _____

Preferred Language for Caregiver(s):_____

Phone #:_____ **Email:**_____

Address:_____

Referral Source:	**School Information:**
Name: _____	**School Name:** _____
Organization:_____	**Grade of Individual:** _____
Phone #:_____	**School Contact Person:**_____
Email: _____	**School Contact Phone #:**_____

Outside Providers (if applicable):
Please provide the: Name/Organization/Phone # if known

Therapist: _____

Psychiatrist: _____

Pediatrician: _____

Please provide a brief description as to why the youth/family would benefit from CFTSS:

_____

_____

_____

_____

Services Requested (check all that apply):

☐ **Other Licensed Practitioner (OLP)**
-assessments, in-home therapy, treatment planning

☐ **Community Psychiatric and Supports**
-incorporate therapy goals into daily life, supportive in-home counseling

☐ **Psychosocial Rehabilitation**
-skill development and building, utilization of coping skills outside the therapy office, socialization skill practice

☐ **Family Peer Support Services**
-support for caregivers and family members raising a youth with mental health/substance use challenges, assistance with information, resources, decision-making and building on natural support

☐ **Youth Peer Support and Training (starting Jan, 2020)**
-support for individuals with mental health/substance use challenges by a young adult/mentor

☐ **Crisis Intervention (starting Jan, 2020)**
-assistance creating and executing an appropriate plan in case of a crisis, support and assistance when a crisis occurs (24/7/365 availability)

Agencies providing these services are listed below. Not all agencies provide all services, but we will work with you to accommodate the request. If you have a preference, please check the box next to the preferred agency. If no preference is indicated the case will be assigned at random.

☐ CHDFS, Inc
☐ Children's Village
☐ MHA of Rockland
☐ Rockland Community Services
☐ St. Dominic's Family Services

Please send referral to Mariel Piña, Rockland C-SPOA Coordinator:

Mariel Piña:
pinam@co.rockland.ny.us
Fax: 845-405-4199
Phone: 845-405-4180 x5