IF THIS IS AN EMERGENCY SITUATION PLEASE CALL 911

ADULT PROTECTIVE SERVICES REFERRALS ARE CONFIDENTIAL

NAME OF PERSON BEING REFERRED

Name: _______________Age/DOB: ___________ Sex: ____________ Language: ________________________

Address: ____

Home Phone #: ___________________________________Cell Phone #: _______________________________

PERSON MAKING REFERRAL (*You may receive follow up call for possible clarification*)

Name: _____________________________________ Phone #: _______________________________________

Referring Agency: __________________Address: ____

Relationship to persons being referred: ____

OTHER PERSONS IN HOUSEHOLD Name and relationship

OTHER CONTACTS Who knows or is involved with the person being referred

Name	**Contact Information**

ARE THERE ANY HOUSING PROBLEMS

- ☐ Homeless
- ☐ Threatened eviction
- ☐ No heat or utilities
- ☐ Other poor housing conditions

DESCRIPTION of problem

PLEASE RETURN PSA REFERRAL BY EMAIL TO RocklandAPS@dfa.state.ny.us or fax referral to 845-364-3567

OR CALL APS INTAKE DEPARTMENT Unit at:

(845) 364-3100 Option 1.5.1 between the hours of 9 **to 5 on business days.**