CATHOLIC CHARITIES
COMMUNITY HEALTH SERVICES
ADULT PROGRAM REFERRAL FORM

SEND TO: Catholic Charities Mental Health Programs **Phone:** (607) 723-9991
290 Front Street
Binghamton, NY 13905
Attn: Tracey Svenson-Gates tsvenson@ccbc.net

Program(s) Individual is Being Referred to (please check box):

☐ **ACE (Assisted Competitive Employment)**

☐ **Reduced Cost Bus Pass**

☐ **Peer Certification** (NYS Academy of Peer Services Curriculum)

Referral Source Information

Agency Name*:* _____ Referral date _____

Referring Person *(Print)**:*** _____ Title _____

Email Address:_____

Address:_____Phone #: (_____)_____Ext _____

Individual's Information

Name: Last _____First _____M_____ DOB: _____

Current Address: _____ Apt. #_____

City: _____ State: _____ Zip: _____

Phone #: (_____)_____Gender: _____ Social Security #: _____

Email Address: _____

Ethnicity: ☐ White ☐ Native American ☐ Latino/Hispanic ☐ Asian/Asian American
☐ African-American/Black ☐ Pacific Islander ☐ Other: specify _____

Primary Psychiatric Diagnosis: (*F-Code **and** Description required)*

Code Description

_____

_____

Reason for Referral:

_____

*If referring for a **discounted bus pass,** how will the individual will be paying for this?*_____

_____ _____ _____
Individual Requesting Services Name (Print) Individual's Signature Date

CSS ELIGIBILITY for TRANSPORTATION

*CSS Number:*_____ *CSS Date:*_____

Application Attached: _____ *OMH 143a* _____ *CSS Functional Assessment Worksheet*

Eligibility determined by: _____ _____
Name / Title Date