CATHOLIC CHARITIES
ADULT MENTAL HEALTH SERVICES
PROGRAM REFERRAL FORM

SEND TO: Catholic Charities Mental Health Programs
290 Front Street
Binghamton, New York 13905 Attn: Kimberly DeSantis

Phone: (607) 723-1804
Fax: (607) 584-4649

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

☐ **ACE (Assisted Competitive Employment)**

☐ **Four Seasons Social Club**: Please include with this referral form: *Psychiatric Assessment*

☐ **Peer Development Part I: Education and Future Goals** ☐ **Peer Development Part II: Certification Process**

☐ **Transportation:** ☐ **Reduced Bus Pass**

☐ **Van Service for Four Seasons Social Club**

Referral Source Information

Agency Name*:* _____ Referral date _____

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

Address: _____

Phone #: (_____) _____ Ext _____

Individual's Information

Name: Last _____ First _____ M_____ DOB: _____

Current Address: _____ Apt. # _____

City: _____ State: _____ Zip: _____

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

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

Primary Diagnosis: (*F-Code **and** Description required. Include **current psychiatric and chemical addiction diagnoses**.)*

Code Description

_____

_____

Reason for Referral:

_____

_____ _____ _____
Individual (Print) Signature Date

FOR OFFICE USE ONLY:

COPIES ROUTED TO:
☐ Four Seasons ☐ Transportation ☐ ACE ☐ Peer Development

CSS ELIGIBLE CSS Number: _____ CSS Date: _____

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

Eligibility determined by: _____ _____
Name / Title Date