Referral for Services

MHA Open Access ☐ Clinic Intake ☐ On Track ☐

Client Name: ____
Date of Birth: ____________________ Gender : ________________________
Home Address: ____
Phone # ____________________ SS# ________________________
Reason for Referral ____
If client is a minor please provide the Parent/Guardian information below:
Parent/Guardian Name: ____
Home Address: ____
Phone # ____

Foster Care Agency ____
Contact Name ______________________________ Phone #: ____________________
Is the child currently residing in a foster residence? YES______ or No____________

Referring Agency: ____
Contact Name: ____
Contact Phone # ____
Contact Email Address: ____

Is this COPS referral? ______________ Yes ____________No
If Yes, please indicate discharge date: __________________

Will the service with the Client or Parent/Guardian need to be provided in Spanish? ___ Yes ____ No

Service Location: (please circle)

White Plains	Mt Kisco	Yonkers
300 Hamilton Avenue Suite 201- second floor White Plains, NY 10601 914-345-0700 x 7300	344 Main Street Suite 301- third floor Mt Kisco, NY 10549 914-345-0700 x 7700	20 South Broadway Suite 1109- 11th floor Yonkers, NY10702 914-345-0700 x 7150
BOCES 131 Midland Avenue North Nyack, NY 10960 914-345-0700 x 7300	**Haverstraw** 20 George Street Haverstraw, NY 10927 914-345-0700 x 7300	**On Track NY** 914-345-0700 x 7725

If you are not sure if your insurance is accepted by MHA please contact us:

Please circle the carrier of the client's Medicaid/Child Health Plus/Family Health Plus:

Affinity Health Plan	Emblem Health (HIP)	Fidelis Care
Hudson Health Plan	United Health Care	Other ___________________

Is client covered by **Medicaid**? _____ Yes ____ No Medicaid ID # ___________________

Is client covered by **Child Health Plus**? ____Yes ___ No CHP ID# ________________________

Is client covered by **Family Health Plus**? ___ Yes ___ No FHP ID # ________________________

Is the client covered by **Medicare**? ______ Yes ____ No Medicare ID# ____________________

We do not accept Medicare through private carriers or Advantage Plans as of 1/1/2014

If the client has a Medicare Supplement please provide the information below

Insurance name: _________________________________ Insurance ID# ____________________

Phone# (front the back of the ID card) ____________________ Group # _________________________

Policy Holder Name: ____

Relationship to Client: ____

Policy Holder Address: ____

Policy Holder Date of Birth: _________________________________

Please fax form to (914) 347-8859 attention Central Scheduler.

Intakes are processed within 24-48 hour of receipt. Due to high call volume we will relay the appointment information to you via email or fax.

Please provide that information where indicated.

If this form is incomplete scheduling can be delayed