MHA The Mental Health Association of Westchester

Referral for Services

MHA Open Access ☐ Clinic Intake ☐ On Track ☐

Client Name: _____
Date of Birth: _____ Gender : _____ _____
Race: White ☐ Black or African America ☐ Hispanic ☐ Alaska Native ☐
American Indian ☐ Asian ☐ Hawaiian/Pacific Islander ☐ Declined to Specify ☐

Ethnicity : Not Hispanic or Latino ☐ Cuban ☐ Mexican ☐ Puerto Rican ☐ Other ☐
Declined to Specify ☐
Preferred Language : _____
Home Address: _____
Phone # _____ SS# _____
Emergency Contact Name _____Phone # _____
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_____

Have you been recently hospitalized? Yes ☐ No ☐ Discharge Date _____
Has discharge paperwork been sent? Yes ☐ No ☐ if not, please provide name of hospital where you were discharged: _____

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

6/1/2017

Service Location: (please circle)

White Plains 300 Hamilton Avenue Suite 201- second floor White Plains, NY 10601 914-345-0700 x 7300	Mt Kisco 344 Main Street Suite 301- third floor Mt Kisco, NY 10549 914-345-0700 x 7700	Yonkers 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