



Planned Respite Referral Application

White Plains, NY 10605

(914)948-4993 or (914)564-3749

FAX: 914-946-9303

Dear Applicant:

Thank you for your interest in Planned Respite.

Planned Respite is a short-term intervention strategy for adults who have a mental health or co-occurring diagnosis and who are experiencing an escalation of symptoms that cannot be managed in the person's home and in the community environment without increased supports. We offer a warm and supportive environment in which people are encouraged to use recovery and relapse prevention skills by specially trained counselors.

Services are voluntary and temporary, and are provided by trained staff in the participant's place of residence or at an alternate authorized temporary housing arrangement. It includes custodial care for a person in order to provide primary care givers (family, significant other, or legal guardian) relief from care responsibilities or supports to the individual to sustain stability in the community and avoid unnecessary hospitalization.

An individual can participate in Planned Respite services for a maximum of 14 nights annually.

Individuals requesting Planned Respite Services must complete a referral application and enclose the following:

- Psychiatric Evaluation (Current within 90 days)
- Psychosocial (Must support eligibility Determination)

Questions and/ or concerns regarding referrals should be made directly to Planned Respite Program Coordinator at (914) 564-3749. All completed referral material should be faxed to (914)946-9303.



Planned Respite Referral Application

Name: _____ Date of Birth: _____
Social Security #: _____ Medicaid #: _____
Military Service: Yes _____ No _____
Address: _____ Apt. #: _____
City: _____ State: _____ Zip: _____
Telephone: _____ Male __ Female __
Citizenship: Yes _____ No _____ (if no, immigration status) _____
Care Manager (if Any) _____ Agency: _____

Ethnicity

Primary Language

- ___ White (Non- Hispanic)
- ___ Latino
- ___ Black (Non- Hispanic)
- ___ Native American
- ___ Asian/Asian American
- ___ Pacific Islander

- ___ English
- ___ Spanish
- ___ Italian
- ___ Russian
- ___ Chinese
- ___ German
- ___ Japanese
- ___ Other

Psychiatric Information

Behavioral Diagnosis and Related Health Conditions:

DSM5 /1CD10

Risk Assessment

- Cruelty to Animals _____
- Suicidal Behavior _____
- Fire Setting _____
- Severe Violence _____
- Homicidal Behavior _____
- Sexual Offense _____

Current Medications: Please List Dosage and Frequency

Does participant require 24 hour supervision? Yes _____ No _____

Is the Participant requesting Planned Respite Services at their place of residence or at an alternate authorized temporary housing arrangement? (Please check one)

Participant's Residence _____ or Temporary housing arrangement _____

How many days are being requested: _____

Start date for requested services: _____

Geographic preference: _____

Emergency Supports and Contact information:

Name: _____

Address: _____

Phone: _____

Relationship: _____

Referral Source

Name: _____

Phone: _____

Agency _____

Fax: _____

Address: _____

Program: _____

Relationship: _____

Reason for request for Planned Respite Services:

Is the participant willing to be connected with additional supports in the community to help prevent hospitalization? Yes ___ No ___

Participant Signature: _____ Date: _____



I, _____, hereby Authorize MHA of Westchester to release and/or receive information in order to Coordinate respite accommodations with either County housing providers or individual's home setting, inclusive of setting, staffing, and services. This information will be held for the sole purposes of coordinating Planned Respite Services for the individual listed above.

I am aware that this consent can be revoked or adjusted at any time to meet my needs. Any revocation or change must be initiated in writing and authorized by me. I understand that the information to be released is confidential and protected. Disclosure to any party other than the one designated above is not permitted.

Signature of Client or Parent/Guardian	Name of Signer	Relationship	Date Signed
_____	_____	_____	_____
Signature of Person Completing Form	Name of Signer	Role	Date Signed
_____	_____	_____	_____

You may review MHA's "Notice of Privacy Practices" for additional information about your rights regarding releasing of private health and medical information. MHA reserves the right to change privacy practices in accordance with the law, which may change the terms of the Notice. A summary of the Notice is posted in each agency location indicating the effective date of the Notice. You were offered a copy of the Notice of Privacy Practices on your first visit at MHA. You may also receive another copy of the Notice if desired and requested.

As more fully explained in the Notice, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and health care operations purposes. In case of emergency, we may need to disclose information about you to ensure that you receive the treatment/care needed.