MHA The Mental Health Association of Westchester

Children and Family Treatment and Support Services (CFTSS)
Referral for Services

Email completed forms via encrypted email to mocciok@mhawestchester.org
For questions, please contact Kathy Moccio at 914-703-8021 or mocciok@mhawestchester.org

Child's Name: _____ Date of Birth: _____

Gender: _____ Preferred Language: _____ Phone Number: _____

Address: _____

Parent/Guardian Name and Phone Number (if different than above):

_____

Medicaid CIN#: _____ Managed Care Plan: _____

Referral Source Information:

Name: _____ Phone Number: _____

Email address: _____

Relationship: _____Agency (if applicable): _____

Reason for referral: _____

_____

_____

Services being requested:

☐ Other Licensed Practitioner (OLP)

☐ Community Psychiatric Supports and Treatment (CPST)*****

☐ Psychosocial Rehabilitation (PSR)*

☐ Family Peer Support Services (FPSS)*

☐ Youth Peer Support and Training (YPST)*

*******If you are a Licensed Practitioner of the Healing Arts (LPHA) recommending CPST or PSR, please complete the following page. **I am a (check one):**

☐ Registered Nurse Professional
☐ Nurse Practitioner
☐ Psychiatrist
☐ Licensed Psychologist
☐ LMSW
☐ LCSW
☐ LMFT
☐ LMHC
☐ Physician
☐ Licensed Creative Arts Therapist
☐ Licensed Psychoanalyst
☐ Physician's Assistant

Recommendation for CFTS Services

This page to be completed only by LPHAs (as detailed on previous page)

*****Please complete all sections.*****

Behavioral Health Diagnoses (Mental Health and/or Substance Use Disorders)**:**

	Diagnosis Name	**Diagnosis Code**	**Dx Provided By**
Primary			
Secondary			
Other			

Areas of Functioning (As a result of the diagnosis listed above, the child/youth has functional impairment that interferes with or limits functioning in at least one of the following areas and is likely to benefit from and respond to the service(s) recommended to prevent the onset or worsening of symptoms.) **Check all that apply:**

Check	**Domain**	**Description of Impairment**
	Self-Direction/Control	
	Self-Care	
	Family Life	
	Social Relationships	
	Symptom Management	

Recommended CFTSS:

Check	**Rehabilitative Service**	**Description of Needed Intervention**
	Other Licensed Practitioner (OLP)	
	Community Psychiatric Supports & Treatment (CPST)	
	Psychosocial Rehabilitation (PSR)	
	Family Peer Support Services (FPSS)	
	Youth Peer Support & Training (YPST)	

By signing below, I am recommending the above named individual for Children & Family Treatment and Support Services.

_____

Print Name

_____ _____ _____

Signature, including credentials NPI # Date