



**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

Date: _____

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:

- | | |
|---|--|
| <input type="checkbox"/> Other Licensed Practitioner (OLP) | <input type="checkbox"/> Family Peer Support Services (FPSS)* |
| <input type="checkbox"/> Community Psychiatric Supports and Treatment (CPST)* | <input type="checkbox"/> Youth Peer Support and Training (YPST)* |
| <input type="checkbox"/> Psychosocial Rehabilitation (PSR)* | |

*****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):**

- | | |
|--|---|
| <input type="checkbox"/> Registered Nurse Professional | <input type="checkbox"/> LMFT |
| <input type="checkbox"/> Nurse Practitioner | <input type="checkbox"/> LMHC |
| <input type="checkbox"/> Psychiatrist | <input type="checkbox"/> Physician |
| <input type="checkbox"/> Licensed Psychologist | <input type="checkbox"/> Licensed Creative Arts Therapist |
| <input type="checkbox"/> LMSW | <input type="checkbox"/> Licensed Psychoanalyst |
| <input type="checkbox"/> LCSW | <input type="checkbox"/> 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