Planned Respite Referral Application

White Plains, NY 10605

(914) 948-4993 or (914) 966-9293
FAX: (914) 813-4364

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 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 Director at (914) 564-3749. All completed referral material should be faxed to (914) 813-4364 for approval.

MHA The Mental Health Association of Westchester

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

___White (Non- Hispanic)
___ Latino
___ Black (Non- Hispanic)
___ Native American
___Asian/Asian American
___Pacific Islander

Primary Language

___ English ___German
___Spanish ___ Japanese
___ Italian ___ Other
___ Russian
___Chinese

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

_____
_____
_____

Can participant self monitor medications? Yes_____ No _____

Any known allergies: Yes_____ No_____
If, so, please list known allergies:_____
_____

Any food restrictions? _____

Outpatient Treatment Provider:
Agency:_____
Program:_____
Contact:_____
Telephone:_____

Substance Abuse History : Please List Drugs of Choice

_____
Length of Time Recipient Has Been Substance Free:_____

Criminal Justice – Current Status
None_____ Incarcerated-Jail ____
Incarcerated_____ Prison_____ CPL 330.20/730_____
Probation _____ Parole
TASC/MHATI_____ Other:_____

Assisted Outpatient Treatment
Does the person have court ordered AOT under Kendra's Law?
Yes___ No___

History of stay at Rockland Psychiatric Hospital? Yes__ No__

To the degree known, list all psychiatric hospitalizations during past three years:

Hospital/ER	Admission Date	Discharge Date

Current Living Situation:

___Room ____Homeless (shelter)
___Own apt ____Homeless (streets)
___ Supervised Living ____ Nursing Home
___ Supported Housing ____ Psychiatric Hospital
___Lives with spouse ____ Lives with Parents
__Correctional facility Other_____

Does participant require 24 hour support? Yes_____ No_____

How many days are being requested: _____

Start date for requested services: _____

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:_____

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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.