Family Support in Central New York

Children and Family Treatment and Support Services (CFTSS)

Date of Referral: _____

Youth First/Last Name: _____ DOB: _____

Youth Medicaid CIN (required): _____Gender: _____

Consent Provided by

☐ Parent ☐ Guardian ☐ Legally Authorized Representative ☐ Youth (18 and older)

Caregiver Name (Printed): _____

Caregiver Signature (Preferred): _____Date:_____

Street Address (inc. apt. number, etc.): _____

City_____ NY Zip Code _____ County _____

Caregiver Relationship to Youth: _____ Caregiver Email:_____

Phone Number(s) - Mobile: _____Alternate Phone:_____

Preferred Time/Method of Contact:_____

Is the youth currently enrolled in a Health Home? ☐ Yes ☐ No

If YES, which HH Agency? _____ Care Manager _____

Is the youth currently enrolled in Medicaid Managed Care Plan? ☐ Yes ☐ No

If YES, what is the MCO Name: _____ ID # _____

Referral Source Name: _____ Title: _____

Referral Source Organization : _____

Referral Address: _____

Referral Phone Number(s) : _____ Referral Email:_____

Name/Agency of Licensed Professional Providing Service Recommendation (if different than referral source) _____.

Services Requested:

☐ Family Peer Support Service (FPSS)

Activities/supports provided to families who are caring for/raising a child experiencing social, emotional, medical, developmental, substance abuse and/or behavioral challenges in their home, school, placement, and/or community. Need to have Medicaid insurance and be a resident of Herkimer/ Madison/Oneida County.

☐ Youth Peer Support and Training (YPST)

Activities/supports provided to youth who are experiencing social, emotional, medical, developmental, substance use, and/or behavioral challenges in their home, school, placement and/or community. Need to have Medicaid insurance and be a resident of Herkimer or Oneida County. Not currently available in Madison County.

School: _____ Grade: _____

District: _____

Special Education Student: ☐ Yes ☐ No IEP Classification: _____

Is youth actively engaged in mental health counseling? ☐ ☐

Mental Health Therapist: _____

Mental Health Therapist Contact # _____ Provider Agency: _____

Medication Management Provider: _____

Medication Management Contact #: _____ Provider Agency: _____

Mental Health Diagnoses (DSM-5 or ICD-10): _____

Diagnosed by: _____

Diagnosis date (within past year): _____

Symptoms of Concern

Check all symptoms that have impacted the youth over the past 60 days:

☐ Depression	☐ Sexually inappropriate	☐ Negative peer interactions	☐ Danger to others
☐ Temper tantrums	☐ Easting disturbances	☐ Delinquent behavior	☐ Alcohol use
☐ Developmental delays	☐ Change to eating	☐ Danger to self	☐ Drug use
☐ Physically aggressive	☐ Runaway	☐ Physical complaints	☐ Impulsive
☐ Self-injury	☐ Phobia	☐ Verbally aggressive	☐ Attention Deficits
☐ Anxiety	☐ Enuresis/Encopresis	☐ Hyperactive	☐ Fire Setting
☐ Sleep disturbances	☐ Sexually aggressive	☐ Problematic social behavior	☐ Truancy

Describe Concerns: _____

_____

_____

_____

Thank you for your referral!

Please contact Elaine Angwin at 315-794-5799/elaine.fscny@gmail.com with questions.
Or, in Madison County, contact Cathy Munson at 315-941-2520/cathy.fscny@gmail.com.

To submit referral:
Please send the completed referral form with any relevant information, signed consent to release information form, and signed medical necessity form.
Send via email to fscny@hushmail.com

Send via fax to 315-864-8398