New York City's Residential Crisis Support and Respite Referral Form

Short-term voluntary programs provide a supportive and home-like environment for people experiencing a mental health crisis in New York City (NYC) as well as help people reintegrate into the community after inpatient care. People (guests) can stay up to 28 days, based on need, and will have 24/7 access to staff support.

These programs are not alternatives to permanent housing or shelter and are only appropriate for people who are **not** at imminent risk of harming themselves or others.

For referral information, call 988 or any of the following phone numbers.

Agency (Program Name)	Beds per Site	Borough	Phone Number	Fax Number
Mosaic Mental Health	10	Bronx	718-884-2992	718-884-2901
Services for the Underserved (Brooklyn Respite)	10	Brooklyn	347-505-0870	877-603-5170
Services for the Underserved (Bright Corner)	3	Brooklyn	646-757-4561	877-603-5170
Ohel Children's Home and Family Services	3	Brooklyn	800-603-6435	718-686-4250
Community Access	8	Manhattan	646-257-5665 (extension 8401)	212-614-1413
ACMH (Garden House or Independence House)	10	Manhattan	212-253-6377 (extension 406 or 408)	212-253-8679
WellLife	3	Queens	718-309-7486	347-542-5847
Transitional Services for New York (Miele's Respite)	10	Queens	718-464-0375	718-217-2366
St. Joseph's Medical Center	3	Staten Island	718-876-2810	718-876-4414

Note: This form includes a check box (Question 3) for an attestation that must only be filled out by a licensed, certified professional for the form to be accepted for review. Completion of this referral form does not guarantee admission into a program. Each admission is determined on an individual basis and based on bed availability. This form should be completed with the voluntary consent of the person being referred.

Referral Date (MM/DD/YYYY): _____

Referral Type: ☐ Self-referral ☐ Family or friend ☐ Outpatient mental health or behavioral health
☐ Managed Care Plan ☐ Inpatient mental health or behavioral health
☐ Comprehensive Psychiatric Emergency Program ☐ Emergency department ☐ Care coordination
☐ Housing ☐ NYC Department of Homeless Services ☐ Shelter ☐ Assertive Community Treatment
☐ Mobile Crisis Team ☐ Safe Options Support team ☐ 988
☐ Other: _____

Potential Guest:

Preferred name (print): _____
Legal name (first and last): _____

Date of birth: _____
Is the guest age 18 or older?: ☐ Yes ☐ No

Address or location: _____
Is the guest an NYC resident?: ☐ Yes ☐ No

Preferred languages: ☐ English ☐ Spanish ☐ Other: _____

Insurance provider (if available): _____
Insurance policy ID number or client identification number: _____

Guest's phone number: _____
Guest's other phone number: _____
Can the guest receive voicemails?: ☐ Yes ☐ No

Guest's email: _____

Emergency contact's name (if available): _____
Emergency contact's relationship to guest: _____
Emergency contact's phone number: _____
Emergency contact's other number: _____

Description of Current Mental Health Crisis:

1. How can this short-term crisis support program help the guest? (Select all that apply.)

☐ Make a wellness and recovery plan. ☐ Prevent hospitalization.

☐ Receive peer support. ☐ Other: _____

2. Is the guest experiencing a mental health crisis or challenges that are contributing to mental health symptoms that cannot be managed well in their home or current environment?

☐ Yes ☐ No

3. Is the guest in imminent risk of hurting themselves or others? **Note:** Only someone who is licensed to attest that the guess is not at imminent risk of hurting themselves or others may check this box. This includes only licensed certified mental health professionals, social workers, psychologists and MDs/psychiatrists. The referral can only be accepted for review if this attestation is provided by a licensed person.

☐ Yes ☐ No

4. Does the guest have a court order to receive Assisted Outpatient Treatment (AOT)?

☐ Yes ☐ No

5. Is the guest medically stable?

☐ Yes ☐ No

6. Does the guest have significant medical conditions or allergies?

☐ Yes ☐ No ☐ Prefer not to answer

List the guest's significant medical condition or allergies:

_____

7. Can the guest take care of their personal needs (for example, eating, using the bathroom and taking prescribed medications) without assistance?

☐ Yes ☐ No

8. Does the guest need on-site accommodations (such as a wheelchair-accessible site or assistance with stairs)?

☐ Yes ☐ No

List the guest's needed accommodations:

_____

9. Does the guest have a safe and stable place to return to after their stay, or is the guest willing to go to a shelter if needed? (**Note:** Homelessness or housing insecurity are not exclusion criteria.)

☐ Yes ☐ No ☐ Unsure

Expected discharge address or location (if known): _____

Referral Provider or Contact:
(Skip to Potential Guest's Signature if this is a self-referral. **Note:** Even if this is a self-referral, a licensed certified person must provide the attestation in Question 3 before the form can be accepted for review.)

Referral provider or contact's name: _____
Licensed credential such as LCSW, LMHC or MD: _____
Relationship to potential guest: _____
Referral provider or contact's phone number: _____
Referral provider or contact's other phone number: _____
Referral provider or contact's fax number: _____
Referral provider or contact's email: _____
Referral agency name (if applicable): _____

_____ _____
Referring provider or referral contact's signature **Date**

_____ _____
Potential guest's signature **Date**

Thank you for your referral.

For staff use only:

Form received date: _____
Form received time: _____

Reviewed by (print name): _____
Reviewer's confirmation that Question 3 has been attested to by a licensed certified person, even if this is a self-referral:
☐ Yes ☐ No

Program supervisor signature: _____

Initial contact with guest (print name): _____
Date of initial contact: _____ Time of initial contact: _____

Expected arrival date: _____
Expected arrival time: _____

Did the guest decline services?: ☐ Yes ☐ No
Why did the guest decline services?: _____

Notes: _____