SCREENING REFERRAL FORM

Take the first step to getting help with healthy food, housing support, rides to services, and more. **This referral form will be used for the purposes of getting members connected to NYS 1115 waiver services by screening them for unmet needs.** Screening is only done with your consent and the information you give is only used to determine your needs and eligibility.

DATE OF REFERRAL

REFERRAL PRIORITY (ROUTINE OR URGENT)

MEMBER INFORMATION

FIRST NAME

LAST NAME

EMAIL ADDRESS

PREFERRED LANGUAGE

MEMBER CONTACT PREFERENCES

PREFERRED CONTACT METHOD (PHONE OR EMAIL)

PHONE NUMBER

BEST TIME TO CONTACT (MORNING, AFTERNOON OR EVENING)

REFERRAL SOURCE INFORMATION

REFERRING STAFF / PROVIDER NAME

DEPARTMENT / PROGRAM

PHONE NUMBER

EMAIL ADDRESS

STREET ADDRESS

IS MEMBER AWARE THAT THIS REFERRAL WILL BE MADE TO AN OUTSIDE ORGANIZATION?

☐ YES ☐ NO

RELEASE OF INFORMATION (ROI)

I authorize my provider / organization, _____ to share information with _____ for referral, eligibility determination, enrollment, and coordination of services.

I also authorize _____ to contact me directly regarding this program.

MEMBER SIGNATURE

DATE