new directions
YOUTH AND FAMILY SERVICES
fostering good.

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Referral for Children and Family Treatment and Support Services

County Specific Contact info:
Erie: Erin Kent (716) 529-1241
Niagara, Orleans, Genesee: Maggie Donohue (716) 535-1731
Allegany, Cattaraugus, Chautauqua, Wyoming: Ian Moore (716) 338-7417
Family Peer Support Referrals (all counties): Laura Lloyd (716) 535-1745

Youth Information

Youth Name: ____________________ Date of Referral: ____________________

Medicaid CIN (*required*): ________________ Insurance Company (*if known):* ____________________

Gender: ☐ M ☐ F ☐ T DOB: ________________ Policy # (*if known):* ____________________

Current Address: ____

City/Town ______________ County: ____________________ Zip ______________

Parent/Guardian Name(s): ____

Relationship(s) if not parent: ______________________________ ☐ *Check if youth is in foster care*

Address: ☐ *Check if same as youth* ____

Phone (cell): Phone (home): Phone (other):

Current or previous Mental Health Diagnosis: ____

Current Mental Health Provider:

Requested Service(s)

☐ *Other Licensed Practitioner (OLP): Assessment/Evaluation, individual therapy, family therapy, crisis intervention*

☐ *Community Psychiatric Supports and Treatment (CPST)∗: Intensive Interventions/Counseling, Crisis Avoidance/Counseling, Crisis Management/Counseling, Rehabilitative Psychoeducation, Strength-Based Service Planning, Rehabilitative Supports*

☐ *Psychosocial Rehabilitation (PSR) ∗: Social/Interpersonal Skills, Daily Living Skills, Community Integration*

☐ *Family Peer Supports & Services (FPSS)∗: Engagement, Bridging & Transition Support, Self-Advocacy, Self-Efficacy & Empowerment, Parent Skill Development, Community Connections & Natural Supports*

∗*A recommendation from a licensed professional is required prior to admission for services with an (*∗*) next to them – see LPHA recommendation form. If the youth is not linked with an LPHA, an OLP evaluation can be provided to assist with determining medical necessity*

Please describe why you are requesting these services, what are the goal(s) for the youth:

Referral Source Information

Name: ______________________________ Role/Relationship to youth: ______________

Agency/Organization (if applicable): ____

Phone: Email:

NDYFS use: Referral Received:________________
Family contact:________________
Referral Source contact:____________