Youth Empowerment Services Referral Form

280 Princeton Avenue Ext., Corning, NY 14830 | **Phone:** (607) 962-3148 **Fax:** (607) 962-8422

Referral Information	
Youth Name	
Date Referred	
Person Completing Referral	
Referral Agency	
Demographics	
Date of Birth	
Address (Only Steuben)	
Grade/School	
Gender	
Gender Identity & Pronouns	
Race	__White __Black __American Indian/Alaska Native __Asian __Hawaiian/Pacific Islander __Other __Unknown __Declined to Answer
Ethnicity	__Not Hispanic or Latino ____Hispanic or Latino
Primary Language	
Caregiver/Guardian Name & Relationship	
Caregiver Contact Information	Home Phone:_____________________ Cell Phone:____________________ Preferred Contact Number and best time to reach them? Is Parent agreeable to referral?
Caregiver Email	
Insurance Information	__Fidelis Medicaid Managed Care __Excellus MMC Policy/Member ID#____________________________ Group #____________________
Referral Reason	
Mental Health Diagnosis (list all applicable)	
Diagnosed By (Name/ Profession)	** Please provide diagnostic/supporting documentation/medical Necessity Form**
Diagnosis Date	
If no diagnosis exists →	Does the youth need a free behavioral health screening by a licensed provider? __Yes __No
Academic Concerns	__Organization __Attendance __Goal Setting __Inattention __Disruptive Behaviors
Mental Health Concerns	__Anger/Aggression __Uncooperative/Defiance __Bullying Victim __Bullying Offender __Social Skills __Self-Image/Self Confidence __Grief (Loss/Death) __Peer Relationships __History of Trauma __Risk of Self-Harm/Suicide __Anxiety __Depression

Family Service Society, Inc.

Planting the Seeds for a Better Tomorrow

	__Adjustment __Family Conflict __Lack of Self-Care Skills __Difficulty Regulating Emotions __Suspected Substance Use __Poor Personal Hygiene __Sexualized Behaviors __Disordered Eating/Sleeping
Adverse Childhood Experiences	__Emotional/Verbal Abuse __History of Physical Abuse __History of Sexual Abuse __History of Neglect __Experienced Poverty __Experienced Caregiver Disruptions __Experienced Poverty __Witnessed Substance Abuse __Parental Incarceration __Parental/Caregiver Mental Illness
Other, Please Describe	
Safety Concerns w/Youth or in the Home, Please Describe	
Is Youth Receiving Current Mental Health Treatment? Please indicate Provider Name(s) and Contact Information of Treatment Team	
Youth Empowerment Services Requested	
1. Children & Family Treatment & Support Services	__Psychosocial Rehabilitation (Skill-Building) Preferred location: __ Bath House __Corning Youth Center __ Hornell Office __ In-Home __Telehealth Monthly hours requested: ______
YES Team Section	
Parental Contact Date	
Verbal Parent Consent Date	
Parent/Child Intake Appointment	Date: Time:
Date Parent Releases Signed	
Service Types Agreed Upon	__PSR (Skill-Building) Individual __PSR Group Comments:
Frequency/Duration of Each Service	Service Type__________________________ Hours Per Month____ Service Type__________________________ Hours Per Month____ Comments:

Please submit completed referral via email to: geec@familyservicesociety.org or Fax to (607) 962-8422

Referral Process

Once referral is received, YES Team will then contact the parent/caregiver, introduce themself(ves), complete the last half of page 2 of the referral, schedule first caregiver/youth session for their part of the Intake and enter the client into the Electronic Medical Record and verify insurance and medical necessity. Referral source will be notified of intake date.