MHACG
MHA of Columbia-Greene

Children & Family Treatment & Support Services

Family Peer Support Referral Form | LPHA Recommendation

CLIENT INFORMATION

Student Last Name: | Student First Name: | DOB: | Date:

Parent/Guardian Last Name: | Parent/Guardian First Name: | Student's School District:

Street Address: | City: | State: | Zip:

Primary Phone: | Phone Type: ○ Home ○ Cell ○ Work

Secondary Phone: *(optional)* | Phone Type: ○ Home ○ Cell ○ Work

Insurance Information

Child's Medicaid CIN:

Health Insurance:

BEHAVIORAL HEALTH INFORMATION

Primary Diagnosis: | Specific Diagnosis: | DX Code:

Secondary Diagnosis: | Specific Diagnosis: | DX Code:

Other:

Areas of Functioning: the child/youth has functional impairment that interferes with or limits functioning in at least one of the following areas and is likely to benefit from and respond to services recommended to prevent the onset or worsening of symptoms.

☐ Self-direction/control ☐ Family life ☐ Symptom management

☐ Self-care ☐ Social relationships ☐ Other

Description of Impairment(s):

Reason for Recommendation: | Child's Strengths:

Services Requested: ☐ FPA ☐ PSR ☐ Audio Telehealth

REFERRAL INFORMATION

Referral Source: | Contact Phone:

Street Address: | City: | State: | Zip:

By signing below I am recommending the above named individual for Children and Family Treatment and Support Services

LPHA Signature | *Printed Name* | *NPI #* | *Date*

Please email completed forms to childrenandfamilies@mhacg.org or fax to 518.828.1196

MHA of Columbia Greene | 713 Union Street, Hudson, NY 12534 | P: 518.828.4619 | F: 518.828.1196 | mhacg.org

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