

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



These short-term voluntary programs provide a supportive and home-like environment for individuals experiencing a mental health crisis. They can also help to reintegrate a person into the community after inpatient care. Guests can stay from 1 day up to 28 days based on need and will have 24/7 access to staff support. These programs are not an alternative to permanent housing or shelter. Programs are appropriate for individuals who are not at imminent risk to the safety of themselves or others. Call 1-888-NYC-WELL (1-888-692-9355) or any of the NYC Residential Crisis Support/Respite programs listed below for referral information.

Agency (Program Name)	Beds Per Site	Borough	Phone Number	Fax Number
Mosaic Mental Health	10	Bronx	(718) 884-2992	(718) 884-2901
S:US (Brooklyn Respite)	10	Brooklyn	(347) 505-0870	(877) 603-5170
S:US (Bright Corner)	3	Brooklyn	(646) 757-4561	(877) 603-5170
OHEL	2	Brooklyn	(800) 603-6435	(718) 686-4250
	1			
Community Access	8	Manhattan	(646) 257-5665 Ext. 8401	(212) 614-1413
ACMH (Garden or Independence House)	3	Manhattan	(212) 253-6377 Ext. 406/408	(212) 253-8679
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WellLife	3	Queens	(718) 309-7486	(347) 542-5847
Transitional Services for NY (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: Completion of this referral form does not guarantee admission. Each admission is determined on an individual basis and is based on bed availability. **This form should be completed with the voluntary consent of the individual being referred.**

Referral Date (MM/DD/YYYY): _____

Referral Type:

- Self-Referral Family/Friend Outpatient MH/BH Managed Care Plan Inpatient MH/BH CPEP
- Emergency Department Care Coordination Housing Department of Homeless Services (DHS)
- Shelter Assertive Community Treatment (ACT) Mobile Crisis Team Safe Options Support (SOS) Team
- Crisis line (NYCWell/988) Other: _____

Potential Guest:

Preferred Name (Print): _____ Legal Name (First, Last) _____

Date of Birth: _____ 18 years or older: Yes No

Address/Location: _____ NYC Resident: Yes No

Preferred Language/s: English Spanish Other: _____

Insurance Provider (if available): _____ Insurance Policy ID#/CIN#: _____

Potential Guest Phone# 1: _____ Phone# 2: _____

Can Receive Voicemail: Yes No

Email: _____

Emergency Contact's Name (if available): _____ Relationship: _____

Emergency Contact Phone# 1: _____ Phone# 2: _____

Description of Current Crisis:

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

- Help with making a wellness and recovery plan Receive peer support Prevent hospitalization
 Transition from inpatient to the community Other: _____

2. Is experiencing a mental health crisis and/or challenges that are contributing to mental health symptoms that cannot be managed well in the person's home or current environment? Yes No

3. Has an Assisted Outpatient Treatment (AOT) order? Yes No

4. Is medically stable? Yes No

5. Has significant medical conditions/allergies? Yes No Prefer Not to Answer

List Significant Medical Conditions/Allergies:

6. Can take care of personal needs and self-preserve (ex. eating, using the restroom, taking prescribed medications) without assistance? Yes No

7. Needs onsite accommodations (ex. wheelchair accessible site, assistance with stairs)? Yes No

Accommodations Needed:

8. Has a safe and stable place to return to after stay and/or is willing to go to a shelter if needed? (NOTE: homelessness or housing insecurity is not an exclusion criteria): Yes No Unsure

Expected Discharge Address/Location (if known): _____

Referring Provider/Referral Contact (Skip to Potential Guest's Signature if this is a self-referral):

Referral Contact's Name: _____ Relationship to Potential Guest: _____

Referral Contact's Phone #1: _____ Phone# 2: _____

Email: _____ Fax: _____

Referral Agency Name (if applicable): _____

Licensed Credential (LCSW, LMHC, MD, if applicable): _____

Referring Provider/Referral Contact's Signature **Date**

Potential Guest's Signature **Date**

Thank you for your referral.

Staff Use Only

Form Received Date: _____ Time: _____

Reviewed By (Print Name): _____

Program Supervisor Signature: _____

Initial Contact with Guest (Print Name): _____ Date: _____ Time: _____

Expected Arrival Date: _____ Expected Arrival Time: _____

Declined Services: Yes No

Reason: _____

Notes:

