

# Broome County Preventive Services Screening / Referral Form

**Youth NAME:**

**Youth DOB:**

<b><u>PURPOSE:</u></b>	<ul style="list-style-type: none"> <li>Screen and facilitate referrals for eligible Youth and Families to appropriate services.</li> <li>Obtain priority access to OMH Outpatient Clinic.</li> </ul>
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<b><u>QUESTIONS &amp; SUBMISSION:</u></b>	Broome County DSS – Specialized Services Attn: Ronica Smith <a href="mailto:Ronica.Smith@dfa.state.ny.us">Ronica.Smith@dfa.state.ny.us</a>	Broome County Probation – Family Services Attn: Chantal Brutovsky <a href="mailto:Chantal.Brutovsky@BroomeCounty.us">Chantal.Brutovsky@BroomeCounty.us</a>
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## SECTION 1 – YOUTH & PRIMARY CAREGIVER INFORMATION

1. Name - Youth	2. Date of Birth - Youth	3. Gender Identity - Youth	4. Date of Referral
5. Name - Primary Caregiver		6. Phone – Primary Caregiver	
7. Email – Primary Caregiver		8. Mailing Address Youth/Caregiver	
9. Health Insurance – Youth  Private                      Medicaid    CIN #: _____  Uninsured                      Unknown		10. Is the YOUTH enrolled in Medicaid-eligible Health Home Care Management?  Yes                      No                      Unknown  <i>If yes – specify:</i>	

## SECTION 2 – REFERRAL SOURCE

11. Name	12. Title	13. Agency/Program
14. Email		15. Phone

## SECTION 3 – HOUSEHOLD COMPOSITION

16. Enter name & DOB for all <b>ADULTS</b> in the household		17. Enter name and DOB for all <b>CHILDREN</b> in the household	
Full Name	Date of Birth	Full Name	Date of Birth
a.		a.	
b.		b.	
c.		c.	
d.		d.	
e.		e.	
f.		f.	

## SECTION 4 – PRESENTING SITUATION

18. Describe present situation/circumstances that may benefit from Preventive Services.
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## SECTION 5 – RISK OF OUT-OF-HOME PLACEMENT

19. Detail how the youth is / may be at risk of eminent out-of-the-house placement.

## SECTION 6 – OTHER SERVICE PROVIDERS

20. Indicate any other community programs or services involved with the youth/family.

## SECTION 7 – MENTAL HEALTH TREATMENT PROVIDER

21. Indicate the Youth / Family **CHOICE** of Mental Health Treatment provider:

Family & Children’s Counseling Services

Greater Binghamton Health Center

Lourdes Center for Mental Health

No Preference

## SECTION 7 – CASE ASSIGNMENT / ROUTING *(DSS internal use only)*

22. Assigned to:

Date:

23. Immediate Contact Needed?

Yes

No

24. Is CONNECTIONS Open?

Yes

No

25. NOTES:

*End of Document*