



Adult Home & Community Based Services (HCBS) and / or Community Oriented Recovery & Empowerment Services (CORE) Referral

Date of Referral: <hr style="width: 100%;"/>	Return Completed Referral	Mail	609 W. Washington St. Geneva, NY 14456
		Fax	(315)789.0555
		Email	HCBSCORE@lakeviewhs.org

HCBS / CORE Participant Information	First Name		Last Name	
	Address		Phone	
			Alt. Phone	
	Date of Birth		Email	
Primary Language		Gender Identity		

Anything we should know? <small>(Recent Incarceration, History of Violence, Weapons in the Home, Sex Offender, Dog in Home, Bed Bugs, etc.):</small>	N/A []	Best Contact Method	<input type="checkbox"/> Phone <input type="checkbox"/> Email
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Participant Insurance Information	MCO Name		Subscriber ID#	
	Contact Name		Contact Phone	
	Contact Email		Medicaid CIN#	
	Primary Diagnosis & ICD 10 Code		Secondary Diagnosis & ICD 10 Code	

Care Management Information	CM Name		Agency	
	Phone		Address	
	Email			
	[] N/A	Not required for CORE Services	Is this a self-referral? (CORE only)	Yes [] No []

Referral Source Information	Source Name		Agency	
	Phone		Address	
	Email			

Care Team Information	Primary Care Name		Phone	
	Therapist Name		Phone	

Services Requested – Please Check All That Apply			
Home & Community Based Services		Community Oriented Recovery & Empowerment Services	
H habilitation Services			Empowerment – Peer Support Services
<ul style="list-style-type: none"> For HCBS Services please include Level of Service Determination and MCO Approval Letters For CORE Services please include LPHA Recommendation Letter if available 			Psychosocial Rehabilitation Services
			PSR with Educational and / or Employment Supports

Primary Goal for Services:	
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Agency Use			
Date Received		Date Forwarded	<input type="checkbox"/> Admission to Foothold <input type="checkbox"/> Admission Note complete <input type="checkbox"/> Upload referral to profile
Forwarded To			