New York City Residential Crisis Support and Respite Referral Form

Short-term voluntary programs provide a supportive and homelike environment for people experiencing a mental health crisis and help them reintegrate with the community. People receiving services at these programs (called "guests") can stay up to 28 days, based on need, with 24/7 access to staff support.

These programs are staffed to provide support through an emotional crisis. Guests are expected to have a plan for where they will live after they complete their stay. The programs are not an alternative to permanent housing or shelter and are only appropriate for people who are not at imminent risk of harming themselves or others. Crisis residences are not able to help people find housing.

For referral information, call 988 or any of the following phone numbers.

Agency (Program Name)	Beds per Site	Borough	Phone Number	Fax Number
Mosaic Mental Health	10	Bronx	(718) 884-2992	(718) 884-2901
Services for the Underserved (Brooklyn Respite)	10	Brooklyn	(347) 505-0870	(877) 603-5170
Services for the Underserved (Bright Corner)	3	Brooklyn	(646) 757-4561	(877) 603-5170
Ohel Children's Home & Family Services	3	Brooklyn	(800) 603-6435	(718) 686-4250
Community Access	8	Manhattan	(646) 257-5665 (ext. 401)	(212) 614-1413
ACMH (Garden House or Independence House)	10	Manhattan	(212) 253-6377 (ext. 406 or 408)	(212) 253-8679
WellLife	3	Queens	(718) 309-7486	(347) 542-5847
Transitional Services for New York (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
TownHome Kings Respite	11	Brooklyn	(718) 473-9860	(877) 341-4347

Note: Completion of this referral form does not guarantee admission into a program. Each admission is determined on an individual basis depending on bed availability. This form should be completed with the voluntary consent of the person being referred.

Referral date (MM/DD/YYYY): _____

Referral type:

☐ Self-referral
☐ Managed care plan
☐ Inpatient mental health or behavioral health
☐ Emergency department
☐ Housing
☐ Shelter
☐ Mobile Crisis Team
☐ 988
☐ Family or friend
☐ Outpatient mental or behavioral health
☐ Comprehensive Psychiatric Emergency Program
☐ Care coordination
☐ NYC Department of Homeless Services
☐ Assertive community treatment
☐ Safe Options Support team
☐ Other: _____

Potential Guest

Preferred name (print): _____
Legal name (first and last): _____

Date of birth: _____
Is the guest age 18 or older? ☐ Yes ☐ No

Address or location: _____
Is the guest an NYC resident? ☐ Yes ☐ No

Preferred languages: ☐ English ☐ Spanish ☐ Other: _____

Insurance provider (if available): _____
Insurance policy ID number or client identification number: _____

Guest's phone number: _____ Secondary phone: _____
Can the guest receive voicemails? ☐ Yes ☐ No

Guest's email: _____

Emergency contact's name (if available): _____
Contact's relationship to guest: _____
Contact's phone number: _____ Secondary phone: _____

Description of current mental health crisis:

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

☐ Make a wellness and recovery plan ☐ Prevent hospitalization

☐ Receive peer support ☐ Other: _____

2. Is the guest experiencing a mental health crisis or challenges that are contributing to mental health symptoms and cannot be managed well in their home or current environment?

☐ Yes ☐ No

3. Is the guest at imminent risk of hurting themself or others?

☐ Yes ☐ No

4. Does the guest have a court order to receive Assisted Outpatient Treatment (AOT)?

☐ Yes ☐ No

5. Is the guest medically stable?

☐ Yes ☐ No

6. Does the guest have significant medical conditions or allergies?

☐ Yes ☐ No ☐ Prefer not to answer

List any significant medical conditions or allergies:

_____

7. Can the guest take care of their personal needs (for example, eating, using the bathroom and taking prescribed medications) without assistance?

☐ Yes ☐ No

8. Does the guest need on-site accommodations (e.g. wheelchair-accessible site, assistance with stairs)?

☐ Yes ☐ No

List the guest's needed accommodations:

_____

9. Does the guest have a safe and stable place to return to after their stay, or is the guest willing to go to a shelter if needed? (Note: Homelessness or housing insecurity are not exclusion criteria.)

☐ Yes ☐ No ☐ Unsure

Expected discharge address or location (if known):

_____

Referral Provider or Contact

Skip to Potential Guest's Signature if this is a self-referral.

Referral provider or contact's name: _____
Licensed credential such as LCSW, LMHC or MD: _____
Relationship to potential guest: _____

Phone: _____ Secondary phone: _____
Email: _____ Fax: _____

Referral agency name (if applicable): _____

_____ _____
Referring provider or referral contact's signature Date

Potential Guest's Signature

_____ _____
Potential guest's signature Date

Thank you for your referral.

For Staff Use Only

Form received date: _____
Form received time: _____
Reviewed by (print name): _____

Program Supervisor signature: _____

Initial contact with guest (print name): _____
Initial contact date: _____ Initial contact time: _____
Expected arrival date: _____ Expected arrival time: _____

Did the guest decline services? ☐ Yes ☐ No
Why did the guest decline services? _____

Notes: _____

Eligible for Stay: ◯ **YES** ◯ **NO**

11.24