

sosreferral@ccocc.org

(607) 742-9095

SAFE OPTIONS SUPPORT REFERRAL

Referring Agency: _____ Referring Worker's Name: _____

Phone Number: _____ E-mail Address: _____

Applicant's Name: _____ DOB/approx. age: _____

Nicknames: _____

Applicant's City: _____ Applicant's County: _____

Gender:

- | | | |
|---|--|---|
| ☐ Male | ☐ Transgender female | ☐ Other |
| ☐ Female | ☐ Non-binary | ☐ Prefer not to answer |
| ☐ Transgender male | ☐ Gender non-conforming | |

Please give a detailed description of the applicant including approximate height, weight, clothing style, and noticeable identifying features (e.g.: tattoos, piercings, etc.)

Common locations and times the applicant is usually at location:

Safety alerts/ behavioral cues:

Methods of contact (phone, e-mail, Facebook Messenger Screen Name, etc.)

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Primary Language: _____

Insurance Type & policy number, if known: _____

Social Security Number, if known: _____

Applicant's Providers (Please include medical, behavioral health and/or substance use providers)

<u>Provider/Clinic Name</u>	<u>Address</u>	<u>Phone Number</u>

Mental Health Diagnosis, if applicable and known

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Substance Use Disorder Diagnosis, if applicable and known

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Medical Diagnosis, if applicable and known

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*Submit referral to: sosreferral@ccocc.org or call the referral line: (607) 742-9095

*Attach psychosocial evaluation if available

****The following consent is helpful, but is not required to submit this referral.***

CONSENT TO RELEASE PROTECTED HEALTH INFORMATION

I authorize _____ (referring provider) to disclose the completed Safe Options Support Referral Application and all related supporting documents (Referral), including confidential medical and mental health information, to Catholic Charities of Cortland County (CCOCC), 33-35 Central Ave, Cortland, NY 13045 for the purposes of conducting a clinical assessment and coordinating health care and related services, including community support services and housing placement assistance, for a period of one hundred and twenty (120) days. As part of this referral process, I understand that the SOS Team will separately obtain my authorization and consent as part of the initial assessment and intake process before providing or coordinating the provision of any additional health care services. I understand that I may revoke my consent to disclose the completed Referral at any time. My revocation may be in writing or verbal with documentation SOS Team Member. I am aware that my revocation will not be effective if the SOS Team has already received the Referral because of my earlier authorization and consent; however, I can instruct the SOS Team to take no further action following its receipt of the Referral. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment nor will it affect my eligibility for benefits.

Name (print)

Signature

Date

Witness Name (print)

Signature

Date