Community Connections of Franklin County Home-Based Crisis Intervention (HBCI)

(Please complete referral in its entirety and email to hbci@communityconnectionsfcny.org)

Phone: (518) 521-3507 Fax (518) 521-3760

Last Name		**First Name**		**DOB:**	
Address **Sex at birth:** M/F **Gender:**	Street _____ Apt. Town State Zip Code _____				
Home Phone		**Cell Phone**		**Alt. Phone**	
E-Mail Address					
Caregiver Name					
Caregiver Contact					
Referral Information					
Name		**Title**			
Agency		**Telephone #**			
Home Based Crisis Intervention Referral Rationale					
The HBCI program is an intensive program to assist with youth/children and their families who are experiencing behavioral concerns who are at risk of hospitalization or inability to stay in the community. Please indicate below the behaviors/symptoms that are of note with this individual/family.					

X	Behavior	Description including dates or frequency
	Suicidal thoughts and/or behaviors	
	Self-injuring behaviors	
	Physical aggression	
	Other high-risk behaviors or notable symptoms	
	Significant decline in functioning	
	Family Conflict	

Behavioral health and/or community services currently or recently utilized by client or family

Service	Description (name of organization/agency, provider, estimated dates)
Inpatient Hospitalization	
Outpatient Counseling	
Behavioral Health Medication Prescription	
Care Management	
Intensive Services (CFTSS/HCBS)	
School IEP or 504 Plan Services	

Provider/Agency Name	Phone Number	Email Address

Is the person being referred aware of the referral? Yes ☐ No ☐

_____ _____

Signature of Referent Date

Community Connections of Franklin County Home-Based Crisis Intervention Program
Individual Consent

I agree that _____, the "Referring Agency or Individual" may disclose my name, address, telephone number, e-mail address, and reason for referral to Community Connections of Franklin County's Home-Based Crisis Intervention Program.

I understand that the information disclosed to Community Connections of Franklin County will only be used to contact me regarding the services they provide and to collaborate with the

"Referring Agency or Individual" on a strictly need to know basis. I understand that the Home-Based Crisis Intervention Program is voluntary, and I am in no way obligated to agree to receive the services they provide.

This consent will be valid for one year form the date I sign this form and that I understand:

1. I may withdraw this consent in writing at any time, except to the extent Referring Agency has already acted in reliance on this consent.
2. This consent is voluntary, and the Referring Agency may not condition treatment on my willingness to sign this consent.
3. I have a right to a signed copy of this consent.

I have read and fully understand this consent form. By signing below, I authorize Referring Agency to disclose information about me consistent with the terms of this consent.

Name of individual: _____

By: _____ Date: _____
Signature of Individual or Representative

Basis of Personal Representative's Authority (if applicable): _____