

**RAPID ENGAGEMENT DEMONSTRATION
CARE FACILITATION REFERRAL**

DATE OF REFERRAL: _____

SSN: _____

Name: _____

DOB: _____

Do you require services in Spanish? Yes No

Gender: Male Female Transgender Race/Ethnicity _____ Marital Status: _____

Permanent Address: _____ City: _____ Zip: _____ Phone: _____

If currently inpatient; Where? _____ planned discharge date: _____

Is someone assisting you with the referral today? Yes No

If Yes, Name: _____ Agency: _____ Phone #: _____

I have worked or am working with other care coordination (case management) services Yes No

If Yes, Name: _____ Agency: _____ Phone #: _____

I am receiving services from a Doctor or other treatment provider? Yes No

If Yes, Name: _____ Agency: _____ Phone #: _____

I can be contacted today at this Address and/ or Telephone number.

Address: _____ Phone#: _____

Additional places where I can be contacted and the best days or times to reach me are the following:

Address: _____ Phone#: _____ Time: _____ to _____

Address: _____ Phone#: _____ Time: _____ to _____

Address: _____ Phone#: _____ Time: _____ to _____

Rapid Engagement Demonstration Eligibility

I am an adult age 18 – 64. Yes No

I live in Monroe County. Yes No

I am eligible for Temporary Cash Assistance. Yes No Don't know

I have had a Substance Use Disorder/Addiction for 2 or more years. Yes No

How many DHS applications have you had in the past 12 months? _____

How many episodes of Emergency Housing have you had in the past 12 month? _____

I participated in completing the referral? Yes No

Other/Comments:

DHS Sanctioned?	Y	N	Unknown
Medicaid Info.			
___ Applied for Medicaid			
___ Receive Medicaid			
Medicaid #:	_____		
(if known)			

***Referrals from Community Providers - Please fax to: 753-5015 or contact
Nicholas Coulter: 753- 2882, 615-9822 (cell), ncoulter@monroecounty.gov or
Donna Jones: 753-2886, djones@monroecounty.gov or
Cheryl Martin: 753-2686, cherylmartin@monroecounty.gov**

(Please attach consent for Release/Exchange of Information)

Office Use Only
Seen by: _____ Date: _____

**RECOVERY CONNECTION
CARE COORDINATION REFERRAL**

DATE OF REFERRAL: _____

SSN: _____

Name: _____
Last First Middle Initial

DOB: _____

Do you require services in Spanish? Yes No

Gender: Male Female Transgender Race/Ethnicity _____ Marital Status: _____

Permanent Address: _____ City: _____ Zip: _____ Phone: _____

If currently inpatient; planned discharge date: _____

Is someone assisting you with the referral today? Yes No

If Yes, Name: _____ Agency: _____ Phone #: _____

I have worked or am working with other care coordination (case management) services Yes No

If Yes, Name: _____ Agency: _____ Phone #: _____

I am receiving services from a Doctor or other treatment provider? Yes No

If Yes, Name: _____ Agency: _____ Phone #: _____

I can be contacted today at this Address and/ or Telephone number.

Address: _____ Phone#: _____

Additional places where I can be contacted and the best days or times to reach me are the following:

Address: _____ Phone#: _____ Time: _____ to _____

Address: _____ Phone#: _____ Time: _____ to _____

Address: _____ Phone#: _____ Time: _____ to _____

Recovery Connection Eligibility

I am an adult age 18 – 64. Yes No

I live in Monroe County. Yes No

I receive Medicaid / am applying / am eligible for Medicaid. Yes No

I have had a Substance Use Disorder/Addiction for 2 or more years. Yes No

I have had 3 or more Inpatient / Detox / Emergency Room visits in the past 12 months, or 4 or more in the past 24 months Yes No

I participated in completing the referral? Yes No

Other/Comments:

DHS Sanctioned? Y N Unknown
Medicaid Info.
___ Applied for Medicaid
___ Receive Medicaid
Medicaid #: _____
(if known)

***Referrals from Community Providers: Please contact / fax to:
Carla Leaks (Restart) 585-546-1271, ext. 6383 (Fax: 585 – 546 – 2607) cleaks@cfcrochester.org or
Doug Hurlbut (RGHS) 585 – 922-2611, (Fax: 585-922-7225) Doug.hurlbut@rochestergeneral.org**

(Please attach consent for Release/Exchange of Information)

Office Use Only
Seen by: _____ Date: _____