LIBERTY RESOURCES
Improving Lives, Building Futures

Crisis Bed Respite Center Referral Form

Referral Date: _____ Medicaid # _____

Name: _____ Date of Birth: _____

Gender: ☐ M ☐ F County of Residence: _____

Home Phone: _____ Cell Phone: _____

Primary Language

☐ English ☐ Spanish ☐ Other

Eligibility

Does client have a stable home to return to post-discharge?	☐ Y ☐ N
Does client suffer from a co-morbid physical injury needing nursing/inpatient care?	☐ Y ☐ N
Is client a threat to themselves or have suicidal ideation?	☐ Y ☐ N
Is client a threat to others or have homicidal ideation?	☐ Y ☐ N
Is client a registered sex offender?	☐ Y ☐ N
Is client able to follow fire safety protocol in the event of a fire?	☐ Y ☐ N

Diagnosis

Mental Health Diagnosis: _____

Substance Abuse Diagnosis: _____

Chronic Medical Condition(s): _____

Description of Crisis: _____

_____

_____

_____

Referral Source

Referral Agency: _____

Agency Address: _____

Person Referring: _____

Phone #: _____ Fax#: _____

E-mail: _____

**Please fax completed form to (315) 820-0191
or call (315) 280-0384

For Office Use Only:

Date received: _____ Accepted: ☐ Denied: ☐ Wait list: ☐

Staff Signature: _____