

**VILLA OF HOPE  
CORE/HCBS Referral Form**

Please Send Referrals to:  
Fax: 585-328-0815  
Email: [homeandcommunity@villaofhope.org](mailto:homeandcommunity@villaofhope.org)

CLIENT DEMOGRAPHIC INFO: Member County \_\_\_\_\_

Member First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Member Last Name/s: \_\_\_\_\_

Member DOB: \_\_\_\_\_ Member Phone #: \_\_\_\_\_

Member Address: \_\_\_\_\_

Member Gender: \_\_\_\_\_ Pronouns: \_\_\_\_\_

Member Race:  Asian/Pacific Islander  Black/African American  Hispanic/Latino  White  Other  
Member Ethnicity:  Puerto Rican  Mexican  Cuban  Dominican  Other Hispanic  Not Hispanic

Insurance Provider: \_\_\_\_\_ Insurance ID: \_\_\_\_\_

Medicaid CIN #: \_\_\_\_\_

HARP Eligibility Status:  H1: HARP-Enrolled  H4: HIV-SNP-Enrolled, meets NYS BH high-needs criteria  
 H9: meets NYS BH high-needs criteria (contact 1-855-789-4277 to enroll in HARP/HIV-SNP)  Other:

**CLIENT MEDICAL INFO:**

Diagnosis Codes:


Qualifying Condition/s:


Medical Alerts/Allergies/Significant Symptoms:

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**CLIENT CONTACTS:**

Emergency Contact Name: \_\_\_\_\_

Emergency Contact Phone #: \_\_\_\_\_

Emergency Contact Relationship to Client: \_\_\_\_\_

Relevant Contacts (Physicians, Counselors, Case Managers):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Recommended Services (Select all that apply):

- CORE Psychosocial Rehabilitation Support  CORE Psychosocial Rehabilitation—education focus
- CORE Psychosocial Rehabilitation—employment focus  CORE Empowerment Services – Peer
- HCBS Ongoing Supported Employment

**REFERRAL INFO:**

Referral Source Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Referring Agency: \_\_\_\_\_ Referral Date: \_\_\_\_\_

Email: \_\_\_\_\_

Attestation of Non-Emergency:

- I understand that this service is not meant to be utilized in a crisis situation as the referral to enrollment process can be lengthy. I attest that this client is not in need of crisis services, and will refer to appropriate timely alternatives if the client is at risk of harming themselves or others.

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**DETERMINATION OF MEDICAL NECESSITY:**

To be completed by a Licensed Practitioner of the Health Arts (LPHA), as defined by:

- Physician • Psychiatrist • Psychologist • Licensed Psychoanalyst • PA • NP • PNP • RPN • LMHC • LCSW
- LCAT • LMFT • LMSW (supervised by an LCSW, psychologist, or psychiatrist employed by the agency)

Note: The CORE Services designated provider will conduct an intake and engage the individual through person centered planning to determine frequency, scope, and duration of recommended services. If the referring agency does not have a licensed provider, nor can receive attestation of medical necessity from one of the client's existing providers, the Villa will make a determination of medical necessity during the intake process.

Based on my knowledge of the individual and clinical expertise, the individual needs and/or would benefit from the above selected CORE Services for the following reasons: (Select all that apply)

- To increase capacity to better manage treatments for diagnosed illnesses
- To prevent worsening of symptoms
- To restore/rehabilitate functional level
- To increase compensatory supports
- To facilitate participation in the individual's community, school, work, or home
- To sustain recovery lifestyle
- To strengthen resiliency, self-advocacy, self-efficacy and/or empowerment
- To build and strengthen natural supports, including family of choice
- To improve effective utilization of community resources

Diagnosis DSM-5 or ICD-10 diagnoses, if known:

\_\_\_\_\_

\_\_\_\_\_  
Signature of LPHA

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

NPI #: \_\_\_\_\_