Unity House of Cayuga County, Inc.
CORE Services
Referral Form

Date of Referral: _____

Referral for: _____ Peer Empowerment _____ Psychosocial Rehabilitation (PSR)

Name: _____

Date of Birth: _____

Address: _____

Phone: _____

Managed Care Organization: _____

Medicaid #: _____

SSN: _____

Mental Health Diagnosis & ICD 10 Code:

_____

Substance Use Disorder & ICD 10 Code:

_____

Care Manager Name & Referral Agency:

_____

Care Manager Phone & Email:

_____

PLEASE INCLUDE A RECOMMENDATION FROM A LICENSED PRACTITIONER OF THE HEALING ARTS (LPHA) IF AVAILABLE. IF REFERRAL SOURCE DOES NOT HAVE AN LPHA RECOMMENDATION, UNITY HOUSE WILL PROVIDE THIS.

Please send completed form to
UH-COREreferrals@unityhouse.org

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Auburn, NY 13021