



ABBOTT HOUSE
Request for CFTSS Services

Organization Name: Abbott House		Date	Time:
Individual's Name (First / MI / Last):		DOB:	CIN#
Person Making Referral/Title:	Agency Name: Contact information: Care Coordinator/Case Planner Name: Contact Information:		
<u>Demographic Information:</u> Address: City: State: Zip: County:	Caregivers Name: Contact information:		
Individual's School Name: School Address: School contact Info: School Contact/Title:			
Presenting Behaviors(Please explain):			
<p style="text-align: center;"><u>CFTSS Services Requested</u> <u>(Please note that ALL services are contingent on Medical Necessity and MCO authorization)</u></p> <div style="display: flex; flex-direction: column; gap: 5px;"><div><input type="checkbox"/> OLP (Other Licensed Practitioners)</div><div><input type="checkbox"/> Licensed Evaluation/Assessment</div><div><input type="checkbox"/> Treatment Planning</div><div><input type="checkbox"/> Psychotherapy</div><div><input type="checkbox"/> Crisis Interventions</div><div><input type="checkbox"/> CPST(Community Psychiatric Supports and Treatment)</div><div><input type="checkbox"/> Psychosocial Rehabilitation</div><div><input type="checkbox"/> Family Peer Support Services</div><div><input type="checkbox"/> Youth Peer Support and Training</div></div>			
Additional Comments:			

All Service Request forms must submitted via:

Secured Fax LHV: (914) 650-1242 or Email to: ServicesReferral-LHV@abbotthouse.net
Secured Fax NYC: (917) 793-3645 or Email to: ServicesReferral-NYC@abbotthouse.net