Safe Options Support (SOS) Program

SAFE OPTIONS SUPPORT REFERRAL

Agency/Program Making Referral:

Referral Source's Name:

Phone: E-mail:

Alternative Contact for Agency/Program Making Referral:

Phone: E-mail:

Identification

Applicant Legal Name: Nickname:

DOB: / / Social Security Number: - -

Does the Applicant Have a Photo ID? Yes No *If yes, please submit a copy of ID with referral application.*

Gender: Race: Ethnicity:

Insurance Information

Does the Applicant Have Health Insurance? Yes No Not Sure

If yes, please provide the following information and submit a copy of insurance documentation with referral application.

Insurance Carrier: Insurance ID #:

Medicaid or Medicare: Yes No Not Sure

Contact Information

Applicant Phone: E-mail:

Applicant's Primary Language: Applicant fluent in English? Yes No Not Sure

Alternative Contact for Applicant: Contact's Info:

Homeless History:

Where did the applicant sleep last night? Please describe:

Type of current living environment / Location: City/Town:

How long has the applicant stayed at the place where they slept last night?

Number of weeks sleeping at a public shelter or places not meant for human habitation during the past 6 months: Please identify the shelter location/environment

Number of homeless episodes during the past year (please describe):

Current Health Services Information:

Please list any medical, mental health, substance use, forensic treatment providers:

Email the Completed Referral Application or any questions about the SOS Program to mysos@ehsny.org
Please include the following items with this referral package, if available:

- Photo Identification
- Health Insurance Documentation
- Psychosocial assessment & psychiatric evaluation

CONSENT TO RELEASE INFORMATION

I authorize (referral source) to disclose the completed Safe Options Support Referral Application and all related supporting documents, including confidential medical and mental health information, to Endeavor Health Services, 795 Indian Church Road, West Seneca, NY 14224 and its affiliated locations for the purposes of conducting clinical assessments, coordinating health care and social services, including but not limited to community support services and housing placement assistance, for a period of one hundred and twenty (120) days. As part of this referral process, I understand that Endeavor Health Services will separately obtain my authorization and consent as part of the initial assessment and intake process before providing or coordinating the provision of any additional services.

I understand that I may revoke my consent to disclose the completed Application at any time. My revocation must be in writing. I am aware that my revocation will not be effective if Endeavor Health Services has already received the Application because of my earlier authorization and consent; however, I can instruct Endeavor Health Services to take no further action following its receipt of the Application.

I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment nor will it affect my eligibility for benefits.

Applicant Name (please print) Applicant Signature Date

Referral Source Name (please print) Referral Source Signature Date