LIBERTY RESOURCES

Integrated Health Care Referral Application

Date of Referral:

Form Updated 10/1/20

REFERRAL INFORMATION

Type Services Needed (check all that apply):

☐ **PHYSICAL HEALTH CARE (PRIMARY CARE)** - Email To PCPReferralGroup@liberty-resources.org or Fax To: (315) 679-5990
☐ **Syracuse Site** ☐ **Fulton Site**

☐ **MENTAL HEALTH TREATMENT** - Email To BHCReferrals@liberty-resources.org or Fax to Site-Specific Fax # noted at bottom
☐ **Syracuse Site** ☐ **Fulton Site** ☐ **Oneida Site** ☐ **Rochester Site**

☐ **SUBSTANCE USE TREATMENT (at Syracuse Site)** - Email To BHCReferrals@liberty-resources.org or Fax (315) 472-1759

REFERRAL SOURCE INFORMATION

Referring Agency/Practice: ☐ **n/a**	**Referral Source Name:** ☐ **self**
Referral Source Phone #: ☐ **self**	**Role of Referral Source:** ☐ **self**

If Referral Source is self, how did you hear about us?

☐ **Current Behavioral Health Center Patient** ☐ **Current Primary Care Patient** ☐ **Family Or Friend**
☐ **Another Provider** ☐ **Sign Outside Of The Practice** ☐ **Social Media** ☐ **Advertisement** ☐ **Insurance Carrier**
☐ **Other (please describe):**

PATIENT INFORMATION

Last Name, First Name, Middle Initial	**Date of Birth:**	**Social Security #**	**Gender:**
Mailing Address	**City, State:**	**Zip Code:**	
Home Phone: ☐ **Preferred** / **Cell Phone:** ☐ **Preferred**	**Primary Language:**	**Is an interpreter needed:** ☐ **YES** ☐ **NO**	
For Minors: Parent/Legal Guardian Name	**Guardian's Relationship to Minor:**		
Is child currently involved in mental health services? ☐ **YES** ☐ **NO** **If yes, where?**	**Primary Language:**	**Is an interpreter needed:** ☐ **YES** ☐ **NO**	

BENEFITS & RESPONSIBILITY

Primary Insurance		**Secondary Insurance** ☐ **N/A**	
Primary Insurance Name	**Policy #**	**Secondary Insurance Name**	**Policy #**
Subscriber's Name	**Subscriber DOB**	**Subscriber's Name**	**Subscriber DOB**
Subscriber's SS#	**Subscriber's Employer**	**Subscriber's SS#**	**Subscriber's Employer**
Subscriber's Relationship To Patient:		**Subscriber's Relationship To Patient:**	
Who is responsible for the bill? ☐ **Self** ☐ **Other – Name:**		**Responsible Party's Relationship to Patient:**	

Responsible Party's Address:
☐ **Same as Above**
☐ **Different from Above – Address of Responsible Party:**

Our Practices are conveniently located at:

Behavioral Health Center (Syracuse)	Phone (315) 472-4471	Fax (315) 472-1759	1045 James Street, Syracuse, NY 13203
Primary Care (Syracuse)	Phone (315) 413-7865	Fax (315) 679-5990	1045 James Street, Syracuse, NY 13203
Behavioral Health Center (Fulton)	Phone (315) 887-1840	Fax (315) 883-8772	14 Crossroads Drive, Fulton, NY 13069
Primary Care (Fulton)	Phone (315) 887-1840	Fax (315) 679-5990	14 Crossroads Drive, Fulton, NY 13069
Behavioral Health Center (Oneida)	Phone (315) 363-0048	Fax (315) 363-0052	218 Liberty Street, Oneida, NY 13421
Behavioral Health Center (Rochester)	Phone (585) 410-3370	Fax (585) 978-7217	175 Humboldt St, Rochester, NY 14610