Email: coreintake@jemcare.org
Phone: 929-259-8227
Fax: 347-795-6065

Community Oriented Recovery and Empowerment (CORE) Referral Form

DATE OF REFERRAL: _____

INSTRUCTIONS: This form must be completed in its entirety to allow JEMCare to verify eligibility for services. Please attach copy of insurance card (front and back) and any clinical documentation of member's diagnosis/ main concerns. Completed Application must be submitted directly to JEMCare via secure e-mail at COREINTAKE@JEMCARE.ORG

MEMBER'S INFORMATION (This section MUST be completed to process the referral)	
Legal Full Name:	
Date of Birth:	Assigned Sex at Birth:
Is the applicant willing to disclose their gender identity? ☐Yes ☐No	
Preferred Gender:	Pronouns:
Medicaid CIN:	Insurance Provider:
Is the applicant enrolled in a HARP plan? ☐Yes ☐No ☐Unsure	
Preferred Language(s):	
Phone:	Email:
Current Address:	

CONSENT AND CONFIDENTIALITY	
Has consent been obtained from the applicant or Legally Authorized Representative for this referral? ☐ Yes ☐No	
Name of Legally Authorized Representative (If Applicable):	
Phone:	Email:
Relationship to Member:	Preferred Language:
Is applicant in Foster Care or under Guardianship? ☐Yes ☐No If YES, please provide details:	
Please note any confidentiality concerns or treatment preferences:	
Applicant Availability for Services (Please include Days and Times i.e. Monday 2pm-5pm):	

REFERRAL SOURCE INFORMATION	
Name of Referrer:	Relationship to Applicant:
Phone:	Email:
Role/Job Title:	Organization/Agency:
Agency Address:	Agency Phone:
Where did you hear about JEMCare?	

HEALTH HOME CARE MANAGER INFORMATION	
Name:	
Phone:	Email:
Agency Name:	Agency Phone:

REASONS FOR REFERRAL	
Primary Concerns (Check all that apply- this section **MUST be completed to process the referral)**	
☐ Behavioral Issues	☐ Trauma Exposure
☐ Emotional Distress	☐ Family Conflict
☐ Social Isolation	☐ Family Conflict
☐ Housing/Financial Instability	☐ Work-Related Issues
☐ Legal Issue	☐ Other (specify):
Symptoms of Concern (Check all that apply- this section **MUST be completed to process the referral)**	
☐ Depression:	☐ Developmental Delays
☐ Anxiety:	☐ Hyperactivity/Attention Deficits
☐ Phobia	☐ Impulsive Behavior
☐ Danger to Self	☐ Runaway/Elopement
☐ Suicidal Ideation(s)	☐ Negative Peer Interactions
☐ Self-Injury	☐ Physical Aggression
☐ Danger to Other(s)	☐ Verbal Aggression
☐ Temper Tantrums/Outbursts	☐ Problematic Social Behavior
☐ Sleep Disturbance	☐ Sexually Inappropriate/Aggressive
☐ Eating Disturbance	☐ Sexually Inappropriate
☐ Substance Use (Alcohol/Drugs)	☐ Other (specify):
Any known safety concerns?	
Diagnosis (If the applicant does not have a verifiable diagnosis, please write N/A. If the client does have a verifiable diagnosis, please attach documentation to confirm):	

SERVICES	
Services being requested (check all that apply):	
☐ Community Psychiatric Supports and Treatment (CPST)	☐ Psychosocial Rehabilitation (PSR)
☐ Family Support and Training (FST)	☐ Empowerment Services – Peer Support
Has the applicant received any previous services? (If YES, please provide details):	☐Yes ☐No
Service Provider:	
Type of Service/s:	
Date of Service/s:	

GOALS	
What goals would the applicant like to accomplish?	
Is there any additional information the applicant or referring party believes is important for our team to be aware of, including urgent concerns or risk alerts?	

CURRENT SUPPORT SYSTEM	
Is the applicant connected to a Primary Care Physician (PCP)? ☐Yes ☐No ☐Unsure	
If yes, please provide details:	
PCP Name:	
Facility Name:	Facility Address:
Phone:	Email:
Is the applicant connected to a mental health provider? ☐Yes ☐No ☐Unsure	
If yes, please provide details:	
Name:	
Facility Name:	Facility Address:
Phone:	Email:
Is the applicant currently receiving support from any other services or agencies? ☐Yes ☐No	
If yes, please provide details:	
Agency Name:	
Type of Support:	
Contact Person:	
Contact Information:	

ADDITIONAL INFORMATION