GATEWAY
HUDSON VALLEY

1 Amy Kay Parkway
Kingston, NY 12401
(845) 331-1261
(845) 331-2112

Personalized Recovery Oriented Services

REFERRAL

To be eligible for admission to a PROS program, a person must be 18 years of age or older, have a designated mental health diagnosis and have a functional disability due to the severity and duration of mental illness.

Applicant Information: Date: _____

Name: _____ Date of Birth: _____

Address: _____

Telephone Number: _____

Insurance Type: Medicaid _____Medicaid ID #_____
Non Medicaid _____ *Please include a copy of the insurance card(s).*

The following is required with the application for review and before an intake can be scheduled:

_____Psychiatric Assessment
_____Psychosocial Assessment
_____Permission to Release/Obtain Information

Please include the following documents, if available and applicable:

_____Health Assessment
_____Substance Abuse Assessment

DSM V & ICD 10 CODES: Diagnoses (Please list Primary Mental Health Diagnosis first):

_____

_____

Please describe the reason for referral to PROS:

_____

_____

_____

Please check the services for which the applicant is being referred:

*Psychiatric Rehabilitation _____
(Groups)

*Psychotherapy/Medication Management_____

*On-Going Employment Supports _____
(For those already employed 10+hours weekly)

Please check areas of functional impairment due to the applicant's mental health condition:

_____Self Care (i.e. personal hygiene, diet, clothing, avoiding injuries, securing health care, complying with medical advice)

_____ Activities of Daily Living (i.e. maintaining a residence, using transportation, day to day self-management, accessing community services, participating in community activities)

_____ Social Functioning (i.e. establishing and maintaining social relationships; interpersonal interactions with primary partner, children or other family members, friends, neighbors; social skills; compliance with social norms; appropriate use of leisure time)

_____ Task Performance (i.e. initiating, persisting in and/or completing tasks commonly found in work, home or educational settings)

_____ Cognitive Functioning (i.e. concentration, attention, information processing, decision making, planning, problem solving, organizing, critical thinking)

Other (please describe):_____

PLEASE NOTE: A referral to PROS MUST be signed by a Licensed Practitioner of the Healing Arts, in accordance with Section 512.7 (c)(iv)(a) of 14 NYCRR Part 512.

I, the undersigned, am referring the above named individual to PROS

_____ _____
Signature Date

_____ _____ _____
Name Title License Number

Agency Affiliation_____

Address_____

Telephone_____FAX_____

Please send completed referrals to:
Gateway Hudson Valley
Attn: Central Intake
1 Amy Kay Parkway
Kingston, New York 12401
or FAX 845 331-2112
or EMAIL GHVreferrals@ghv.org

Please feel free to contact the PROS Clinical Director (x309) or PROS Program Manager (X297) with any questions regarding the PROS Program.