Astor Services
Home Based Crisis Intervention (HBCI)
Serving Westchester, Rockland, Putnam,
Dutchess, Ulster, Columbia and Greene counties

HOME BASED CRISIS INTERVENTION (HBCI) REFERRAL FORM

Home Based Crisis Intervention (HBCI) serves clients ages 5 to 20* living in Westchester, Rockland, Putnam, Dutchess, Ulster, Columbia and Greene counties who are at immediate risk for inpatient hospitalization. This may include concerns related to safety to self or other(s) or a significant decline in functioning. If the client does not present with safety risks, please explain why the family requires crisis intervention services. HBCI has the best outcomes when the client and caregivers participate for 4-6 weeks with a minimum of two 90-minute in-home visits per week. (*Youth 18+ must be living with their caregivers and be willing to participate in family therapy).

HBCI referrals are submitted and processed on a county-specific basis.
Please email this completed form to the appropriate HBCI email address indicated in the listing below.
Case consultations are also available by email or calling HBCI at the county phone number provided.

For referral submissions by fax, please fax referrals for all counties to (845) 554-1376.

✓	COUNTY	EMAIL	PHONE
	Columbia	HBCIColumbia@astorservices.org	(518) 217-6299
	Dutchess	HBCI@astorservices.org	(845) 554-1365
	Greene	HBCIGreene@astorservices.org	(518) 217-2299
	Putnam	HBCIPutnam@astorservices.org	(845) 210-5599
	Rockland	HBCIRockland@astorservices.org	(845) 580-5890
	Ulster	HBCI@astorservices.org	(845) 554-1365
	Westchester	HBCIWestchester@astorservices.org	(914) 218-4699

Client Name:

DOB:

Parent/Guardian:

Address:

Home Number:

Cell Number:

Diagnosis:

Medications:

Referent Name/Agency:

County of residence:

Referent Telephone:

Referral Date:

REASON FOR REFERRAL

Information about the reason for referral, including symptoms/behaviors contributing to current risk for inpatient hospitalization or out-of-home placement:

Family Strengths:

Family's Identified Concerns:

CONCERNING BEHAVIORS

Please select (X) and describe crisis behaviors of concern occurring in the **PAST TWO WEEKS:**

X	Behavior	Description
	Suicidal thoughts and/or behaviors	
	Self-injuring behaviors	
	Physical aggression	
	Other high-risk behaviors	
	Significant decline in functioning	
	Family conflict	
	Other symptoms / behaviors	

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CLINICAL & COMMUNITY CONNECTIONS

Identify behavioral health and/or community services currently or recently utilized by client or family. Please select (X), indicate participants, and describe:

X	Service	Description (name of organization/agency, provider, estimated dates, etc.)
	Inpatient Hospitalization	
	Partial Hospitalization	
	Outpatient Counseling	
	Outpatient Psychiatry	
	Care Management	
	Intensive Services (CFTSS/HCBS)	
	School IEP or 504 Plan Services	
	CPS or Prevention Services (DCFS)	
	Other services	