Catholic Charities of Cortland County
CARING FOR OUR COMMUNITY ONE PERSON AT A TIME

SOS SAFE OPTIONS SUPPORT NEW YORK STATE

RSS

SOS Cortland-Tompkins-Tioga Team

sosreferral@ccocc.org (607) 742-9095

SAFE OPTIONS SUPPORT REFERRAL

Referring Agency: ___________________________ Referring Worker's Name: ______________________

Phone Number: ____________________________ E-mail Address: _______________________________

Applicant's Name: _____________________________________ DOB/approx. age: __________

Nicknames: ________________________________

Applicant's City: ____________________________ Applicant's County: ____________________

Gender:

☐ Male ☐ Transgender female ☐ Other

☐ Female ☐ Non-binary ☐ Prefer not to answer

☐ Transgender male ☐ Gender non-conforming

Please give a detailed description of the applicant including approximate height, weight, clothing style, and noticeable identifying features (e.g.: tattoos, piercings, etc.)

Common locations and times the applicant is usually at location:

Safety alerts/ behavioral cues:

Methods of contact (phone, e-mail, Facebook Messenger Screen Name, etc.)

Primary Language: ______________________________

Insurance Type & policy number, if known: ____

Social Security Number, if known: ___________________________

Applicant's Providers (Please include medical, behavioral health and/or substance use providers)

Provider/Clinic Name	Address	Phone Number

Mental Health Diagnosis, if applicable and known

Substance Use Disorder Diagnosis, if applicable and known

Medical Diagnosis, if applicable and known

*Submit referral to: sosreferral@ccocc.org or call the referral line: (607) 742-9095
*Attach psychosocial evaluation if available
The following consent is helpful, but is not required to submit this referral.

CONSENT TO RELEASE PROTECTED HEALTH INFORMATION

I authorize ___________________________________ (referring provider) to disclose the completed Safe Options Support Referral Application and all related supporting documents (Referral), including confidential medical and mental health information, to Catholic Charities of Cortland County (CCOCC), 33-35 Central Ave, Cortland, NY 13045 and Rehab Support Services, Inc (RSS), PO Box 375, Owego, NY 13827 for the purposes of CCOCC and RSS operating jointly under Safe Options Support Team (SOS Team) conducting a clinical assessment and coordinating health care and related services, including 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 the SOS Team 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 health care services. I understand that I may revoke my consent to disclose the completed Referral at any time. My revocation may be in writing or verbal with documentation SOS Team Member. I am aware that my revocation will not be effective if the SOS Team has already received the Referral because of my earlier authorization and consent; however, I can instruct the SOS Team to take no further action following its receipt of the Referral. 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.

______________________________	________________________	__________
Name (print)	Signature	Date
______________________________	________________________	__________
Witness Name (print)	Signature	Date