



**Community Oriented Recovery and Empowerment Services**

329 North Salina St. Syracuse NY 13202

Please send Referral Form, Consents, and LPHA Recommendation (if possible) to:  
modonnell@helio.health

**Client Information**

Date of Referral: \_\_\_\_\_

Referring Agency/Case Manager: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

Client Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Gender: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

MCO: \_\_\_\_\_ MCO ID: \_\_\_\_\_

Medicaid CIN: \_\_\_\_\_

**Services Requested**

- Psychosocial Rehabilitation  Family Support and Training  
 Empowerment Services – Peer Support

**Client goals in relation to CORE service(s):**

**Client strengths/barriers:**