Home and Community Based Services

329 North Salina St. Syracuse NY 13202
Please send Referral Form, Consents, LOSD, and summary 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

- ☐ Pre-Vocational Services
- ☐ Education Support Services
- ☐ Transitional Employment
- ☐ Habilitation
- ☐ Ongoing Supported Employment
- ☐ Intensive Supported Employment

Client goals in relation to HCBS Service(s):

Client strengths/barriers: