Community Oriented Recovery and Empowerment Services

329 North Salina St. Syracuse NY 13202
Please send Referral Form, Consents, and LPHA Recommendation (if possible) to:
HCBS-CORE@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: