NEW YORK ASSOCIATION ON INDEPENDENT LIVING

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OPEN DOORS PEER SERVICES REFERRAL FORM

Date: _____

Participant Name: _____

Medicaid # (if available): _____

Participant Phone or best method of contact: _____

Family/Advocate name and contact information: _____
(please indicate if guardian) _____

Facility Contact Information: _____
(name/position)

_____
(Facility name)

_____
(Street, City, State, Zip)

_____
(phone/email)

Date of Birth: _____ County: _____

Room Number: _____ Primary Language: _____

Primary Diagnosis: _____

Comments (including peer preferences):

_____

_____

Please attach any relevant information.
For a list of local emails and fax numbers to send referrals to go to www.ilny.org/peer
Or send to: Open Doors Transition Center – Peer Advocate
Fax: 518-465-4625
Email: zgarafalo@ilny.org or kbell@ilny.org
Phone: 518-465-4650
For confirmation of receipt of a referral, please email Zach Garafalo or Katy Bell.