NEW YORK ASSOCIATION ON INDEPENDENT LIVING

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OPEN DOORS TRANSITION CENTER REFERRAL FORM

☐ Section Q Referral ☐ PASRR Referral ☐ Other Referral

Date: _____

Resident Name: _____

Medicaid # (if available): _____

Resident 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: _____

Comments: _____

_____

Please attach a **FACE SHEET** and any other relevant information.
For list of Regional emails and fax numbers to send referrals to go to www.ilny.org
Or send to: Open Doors Transition Center
Fax: 518-465-4625
Email: secq@ilny.org
Phone: 518-465-4650
If you would confirmation of receipt of a referral, please email secq@ilny.org