Onondaga County System of Care
Outreach and Navigation Team
Referral Form

Referral Source **Date:**

Name:

Email:

Phone:

Individual Referred

Name:

Address:

Phone:

DOB:

Medicaid #: Last 4 SS#:

Individual Notified: Yes☐ No☐

Race/ Ethnicity:

Description of individual:

Is there a SPOA? Yes☐ No☐ Unknown☐

Reason for referral: (Please include any known providers, typical locations ect.)

Desired Outcome:

Please send the referral to socoutreach@ongov.net via an encrypted email.