RISE Saratoga County Court-Based Mental Health Navigator
Referral Form

Date of Referral:

Applicant Name:

DOB: Applicant Phone:

Applicant Email:

Applicant Current Location:

Medicaid #: NYSID #:

Last Four Digits of Social Security #:

Court Name:

Attorney Name:

Attorney Phone:

Legal Charge(s):

☐ Misdemeanor:

☐ Felony:

Next Court/Hearing Date:

Mental Health Diagnosis (if applicable):

The individual being referred needs assistance with (Check all that apply):

☐ Mental Health Evaluation/Treatment

☐ Substance Use and Addiction Evaluation/Treatment

☐ Linkage to specialized programs (e.g., SPOA, SOS, CTI)

☐ Education on court process

☐ Trauma treatment

☐ Domestic violence services

☐ Aging services

☐ Housing

☐ Transportation

☐ Food

☐ Other (please list):

Referral Source (Name, Title, Relationship):

Referral Source Contact Information:

Additional Information:

Fax or email referral to Navigator Erika Boisvenue:

Fax: 518-587-8703

Email: eboisvenue@riseservices.org

Phone: 518-577-8158

For further information be sure to check out our website at www.riseservices.org