Office for People With Developmental Disabilities

Statewide Forensic Advisory Committee (SFAC) Referral Form

Bureau of Intensive Treatment Services (BITS)

Name:	**DOB:**	**Age:**	**Gender:**	**TABS ID:**	**Referral Date:**
Referring Team:		**Who will present:**			
Current location of individual (State-Operated or Voluntary Provider residence, Family Care, Psychiatric Facility, Hospital, Jail/Prison, Other (specify)):					

Current Legal Status (e.g., Criminal Procedure Law (CPL), Mental Hygiene Law (MHL)) ☐ CPL §730.40 Final Order (-> Article 15) ☐ CPL §730.40 Temporary Order ☐ CPL §730.50 Commitment Order ☐ CPL §330.20 Not Responsible ☐ Family Court ☐ Article 15, MHL ☐ Other (describe):	
Sex Offender Registration Act (SORA) Level:	**Probation/Parole/Strict and Intensive Supervision and Treatment (SIST)/Assisted Outpatient Treatment (AOT)?** *(note expiration date, where applicable):*

Documentation	**Check, if attached**
Cover Letter from Director (*required)*	☐
Reason for Review Form (*required)*	☐
Legal History Form *(if not included in the Psychological Report)*	☐
Local Review Committee Minutes (*required)*	☐
Psychological Report (*required) (see sample)*	☐
Risk Assessment *(if not included in the Psychological Report)*	☐
Risk Management Plan *(where applicable, from the sending and receiving team)*	☐
Behavior Support Plan *(where applicable, from the sending and receiving team)*	☐
Functional Behavior Assessment *(if applicable)*	☐
Receiving Team Response *(if applicable)*	☐
Site Assessment *(if applicable)*	☐
Application for Change in Status/Privileges Form *(if applicable)*	☐
Other Supporting documents (e.g., psychiatric, court orders, medication, medical)	☐

Signature: ____ Date: ________________

Type Name: ____ Title: ________________

Staff Person who prepared SFAC Referral Packet

Signature: ____ Date: ________________

Print Name: ____, Director ☐ State Operations ☐ Regional Office