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www.centerlighthealthcare.org

Referral Form

CL Intake (M) ID: _____

Please fill out this form as completely as possible and send to **referrals@centerlight.org** or fax to **315-825-4810**. You may also call us at **1-877-212-8877 (TTY 711)** M-F, 8AM-8PM. Message service also available on nights & weekends.

Account Rep: _____ Fax Number: 315-825-4810 Email: referrals@centerlight.org

POTENTIAL PROSPECT (PP) REFERRAL INFORMATION

Last Name: _____ First Name: _____

Home #: _____ Cell #: _____ Email: _____

Address: _____ Apt #: _____ City: _____ State: NY Zip Code: _____

Date of Birth: _____ Gender: ☐ Male ☐ Female SSN: _____

(must be 55 years old or over)

Current Location: ☐ Home ☐ SNF/LTC ☐ Hospital ☐ Other: _____

Lives with: ☐ Family ☐ Alone ☐ Other: _____ Language Spoken: _____

Medicaid #: _____ Needs Assistance with Medicaid: ☐ Yes ☐ No

Medicare #: _____ Other Insurance: _____

PP needs assistance: ☐ Bathing ☐ Dressing ☐ Meal Prep ☐ Feeding ☐ Toileting ☐ Ambulating ☐ Forgetfulness

Is the PP receiving hospice care? ☐ Yes ☐ No Was PP informed of referral: ☐ Yes ☐ No

Was the CFEEC Assessment done? ☐ Yes, date: _____ ☐ No ☐ N/A Interested in CDPAS? ☐ Yes ☐ No

If yes, please complete CDPAS paperwork and provide information on the back of this form.

Type of case: ☐ New to Services ☐ MMC ☐ Plan to Plan (PTP)

Is the PP currently receiving home care services? ☐ Yes ☐ No

If yes, vendor and service provided: _____

Additional comments: _____

PACE education completed: ☐ Yes ☐ No Is PP interested in attending our Day Health Center (DHC)? ☐ Yes ☐ No

Is PP interested in attending our Start of Care Fair at the DHC? ☐ Yes ☐ No

Mutual Case: ☐ Yes ☐ No If Yes, Name of Mutual Case: _____

Family/Caregiver Name: _____ Relationship: _____

F/C Home #: _____ F/C Cell #: _____ F/C Email: _____

PP PRIMARY CARE PHYSICIAN (PCP) *(Complete worksheet in the back for more providers/medications.)*

Name: _____ Phone: _____

Address: _____ Apt #: _____ City: _____ State: NY Zip Code: _____

REFERRAL SOURCE INFORMATION

Referral Source Name: _____ Date of Referral: _____

Referral Source Type: _____ Referrer Contact Name: _____

Referrer Phone: _____ Referrer Email: _____

Please complete the provider list on the back of this page. Thank you for considering Teamcare! Send referrals by email to referrals@centerlight.org or fax to 315-825-4810. For questions, call us at 1-877-212-8877.

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Prospect Worksheet

CL Intake (M) ID: ______________

Potential Prospect (PP) Last Name: ______________________________ PP First Name: ______________________________

Doctors / Specialists / Pharmacy	Par / Non-Par	Notes
Name: ____________ Phone: ____________ Address: ____________	☐ P ☐ NP	____________
Name: ____________ Phone: ____________ Address: ____________	☐ P ☐ NP	____________
Name: ____________ Phone: ____________ Address: ____________	☐ P ☐ NP	____________
Name: ____________ Phone: ____________ Address: ____________	☐ P ☐ NP	____________
Name: ____________ Phone: ____________ Address: ____________	☐ P ☐ NP	____________
Name: ____________ Phone: ____________ Address: ____________	☐ P ☐ NP	____________

Note: *Participant can also see a site PCP or an in-home provider who practice in Family Medicine, Internal Medicine, General Practice, Gynecology and Geriatrics. Specialists can serve as a PCP if they provide comprehensive primary care in addition to their specialty. Types of specialists that may commonly provide primary care include cardiologists, endocrinologists, neurologists and rheumatologists. Certain Behavioral Health related medical specialists might also serve as PCP.*

Medications (Need to be on Formulary)	Dose	Frequency	On Formulary	Notes
____________	______	______	☐ Y ☐ N	______
____________	______	______	☐ Y ☐ N	______
____________	______	______	☐ Y ☐ N	______
____________	______	______	☐ Y ☐ N	______
____________	______	______	☐ Y ☐ N	______
____________	______	______	☐ Y ☐ N	______
____________	______	______	☐ Y ☐ N	______
____________	______	______	☐ Y ☐ N	______
____________	______	______	☐ Y ☐ N	______
____________	______	______	☐ Y ☐ N	______

CDPAS Personal Assistant (PA/Aide)

Note: The PA cannot be the participant's spouse or Designated Representative/Power of Attorney.

PA 1 Name: ____________ Phone: ____________ Email: ____________

Is PA 1 Registered with Fiscal Intermediary (FI)? ☐ Yes ☐ No Relationship to PP: ____________

PA 2 Name: ____________ Phone: ____________ Email: ____________

Is PA 2 Registered with FI? ☐Yes ☐No Relationship to PP: ____________

PA 3 Name: ____________ Phone: ____________ Email: ____________

Is PA 3 Registered with FI? ☐Yes ☐No Relationship to PP: ____________

FI employee verifying registration: ____________ **FI Contact #:** ____________

Designated Rep Name (if not PP): ____________ **Phone:** ____________ **Email:** ____________

3 Steps for CDPAS Application: (1) PA register with FI, (2) PA/PP complete CDPAS paperwork & (3) PA complete background check.

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Last review date: 11/23/2021