Mail, e-mail, or fax completed application,
with required documentation to:

- Victoria Grems, Practice Manager
  The Arc Madison Cortland
  701 Lenox Avenue
  Oneida, NY 13421
- E-mail application to: victoria.grems@arcofmc.org
- Fax application to: (315) 363-9286, ATTN: Victoria Grems

The Arc Madison Cortland New York

THE Arc MADISON CORTLAND CLINIC SERVICES REFERRAL

DATE REFERRAL MADE: _____ DATE REFERRAL RECEIVED: _____

DEMOGRAPHIC AND INSURANCE INFORMATION – MUST COMPLETE ALL LINES:

First Name: _____ Middle Initial: _____ Last Name: _____
Date of Birth: _____ Social Security Number: _____
Address: _____ County: _____
City: _____ State: _____ Zip Code: _____
Home Number: _____ Primary Diagnosis: _____
Cell Number: _____ ☐ Check to authorize text messaging

Living Situation:

□ IRA – List Agency it is operated by: _____
□ Family Care – List Agency it is overseen by: _____
□ With Family – Relation to referred individual: _____
□ Independent

Insurance Information:

Medicaid Number: _____ Medicare Number: _____
Other Insurance (Fidelis, BC/BS, etc):
Insurance Name: _____ Policy Number: _____
Insurance Name: _____ Policy Number: _____

Contact Information:

Person completing application: _____ Relationship to Applicant: _____
Phone Number: _____
Care Manager: _____ Email Address: _____

Contact for Scheduling: ☐ Applicant ☐ Care Manager ☐ Other: _____
Phone Number: _____
Email Address: _____

Provider Information:

Primary Care Provider: _____ Phone Number: _____
Address: _____

Psychiatrist: _____ Phone Number: _____
Address: _____

Additional Information:

Is Applicant currently receiving OT, PT, or Counseling Services elsewhere (to avoid duplication of service)?
□ No □ Yes If "Yes", where? _____

Is Applicant currently attending Day Habilitation?
□ No □ Yes If "Yes", where? _____

Does Applicant have a legal Guardian?
□ No □ Yes*
If "Yes", Guardian's Name: _____ Phone Number: _____
Address: _____ E-Mail: _____

**Guardian must be notified and must give consent for the requested service(s).*

REFERRAL REQUEST – SELECT ALL THAT YOU ARE REQUESTING

PRESCRIPTION FROM PCP REQUIRED FOR ALL THAT HAVE (**) NEXT TO THEM

ONGOING SERVICES

- □ Psychiatry
- □ Podiatry
- □ Social Work
- □ Physical Therapy**
- □ Occupational Therapy**
- □ Speech Therapy**
- □ Nutrition

SPECIALIZED ASSESSMENTS

- □ Eligibility Testing (Includes IQ and Funcional)
- □ Full Scale IQ
- □ Functional Assessment
- □ Comprehensive Diagnostic Evaluation (Autism Testing)
- □ Guardianship
- □ Sexuality Assessment
- □ Healthcare Proxy
- □ Medical Consent (procedures only)
- □ Swallowing Evaluation**
- □ Sensory Assessment**
- □ Wheelchair**
- □ Adaptive Equipment**
- □ Other: _____

Reason for Request (Please describe to the best of your ability the behavior, deficit or problem. Also indicate what other services may have been attempted to address this):

_____

_____

_____

_____

_____

REQUIRED ATTACHMENTS FOR THE REFERRAL

CLINIC ENROLLMENT FOR ONGOING SERVICES

- □ PCP script for OT, PT or ST Evaluation
- □ Medicaid Card
- □ Medicare Card (if applicable)
- □ 3rd Party Insurance Card (if applicable)
- □ Completed Insurance Form (if applicable)
- □ OPWDD Eligibility Letter and/or NOD
- □ Psychological Assessment
- □ LifePlan
- □ IEP (if currently enrolled in school)
- □ Legal Guardianship Paperwork (if applicable)
- □ Medication List and Last Visit Note (for psychiatry referrals only)

SPECIALIZED ASSESSMENTS (onetime evaluation)

- □ PCP script for Swallowing Eval, Wheelchair Assessment, Adaptive Equipment, Sensory Assessment
- □ Medicaid Card
- □ Medicare Card (if applicable)
- □ 3rd Party Insurance Card (if applicable)
- □ Completed Insurance Form (if applicable)
- □ LifePlan (if they have one)
- □ IEP (if enrolled in school or just aged out)
- □ Previous Psychological Assessments
- □ Medical Reports
- □ Letter from OPWDD requesting the Assessment (if already submitted to eligibility committee and they are requesting additional tests)

OFFICE USE ONLY

I have reviewed all of the medical documents forwarded to the Clinic related to the care of this individual and give □ approval for the aforementioned services --OR-- □ denial for the aforementioned services.

Medical Director's Signature: _____ Date _____