

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

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



CLINIC SERVICES REFERRAL

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
E-mail: _____
Emergency Contact (Name & Phone Number): _____

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: _____ E-mail 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

ONGOING SERVICES

- ☐ Psychiatry (must also select Social Work)
- ☐ Podiatry
- ☐ Social Work
- ☐ Physical Therapy
- ☐ Occupational Therapy
- ☐ Speech Therapy
- ☐ Nutrition

SPECIALIZED ASSESSMENTS

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

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 Notice of Decision (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)
- ☐ OPWDD Eligibility Letter or NOD (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

Date Referral Made: _____ **Date Referral Received:** _____

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: _____