EVERCARE CHOICE

REFERRAL FORM

Referral for MLTCP

EMAIL form to enrollmentservices@evercare.org
or CALL 845-569-0500 ✦ Press 0 for Enrollment Services

REFERRAL SOURCE INFORMATION

REFERRAL SOURCE_____ PHONE [ ] –

ORGANIZATION _____ DATE ____/____/____

REFERRAL INFORMATION

NAME OF PATIENT _____ PHONE [ ] –

ADDRESS _____

DATE OF BIRTH ____/____/____ GENDER ☐ Male ☐ Female SSN# ___–___–___

CONFLICT FREE ASSESSMENT [CFEEC] COMPLETED ☐ Yes (date ____/____/____) ☐ Needs CFEEC

MEDICAID# _____ MEDICARE# _____ OTHER INSURANCE _____

☐ Needs to apply for Medicaid ☐ Needs to apply for Pooled Trust

HOME CARE PROVIDER(S) [*if any*] _____

FAMILY OR CAREGIVER NAME: _____

RELATIONSHIP _____ PHONE [ ] –

WHAT SERVICES ARE BEING REQUESTED:

☐ Personal Care Aide ☐ Social Day Care ☐ Skilled Services [RN, PT, OT, ST]
☐ Medical Social Worker ☐ Transportation ☐ Home Delivered Meals

OTHER:

_____

_____

_____

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