PRESENCE SERVICES
REFERRAL FORM

Please note that this form is fillable; however, the form can also be printed and filled out.

Upon completion of the form:
✓ Save the form as a document.
✓ Send the form **&** eligibility documents by secure email, fax, or hard copy:
a. **EMAIL**: info@presencedevelopmental.com
b. **FAX**: 315-515-5194
c. **MAIL TO**: 115 Fall Street, Seneca Falls, NY 13148

Eligibility for Presence includes individuals of all ages, who are determined by the Office for People with Developmental Disabilities (OPWDD) to have a developmental disability and have Medicaid insurance. ***Our team is ready to support you!***

For further eligibility information, visit the following website Independent Practitioner Services for Individuals with Developmental Disabilities | Office for People With Developmental Disabilities (ny.gov)

Referred Individual Name: Date of birth:
*Note: Must provide date of birth for at least one legal guardian, if the individual is under 18.

Medicaid ID#

Phone #: ☐ **By checking this box, you agree to receive text messages from Presence related to this referral and schedule. Msg + data rates may apply.**

Best time of day to contact: Specify the language spoken if other than English:

Select & describe the reason(s) for referral:
☐ Social Work ☐ Behavioral Support Therapy
☐ Occupational Therapy ☐ Speech-Language Pathology ☐ Physical Therapy

Description:

Preferred Service Location: ☐ In-home ☐ Community ☐ office

Email address for the patient portal:

Home Street Address, City & Zip:

Current living setting:
☐ Family/Relative Home
☐ Community Residence

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☐ Individualized Residential Alternative
☐ Private Residence (on own)

Additional Insurance Information:

Insurance Name: Insurance ID#
Primary Subscriber (if not Individual referred):
Primary Subscriber Date of Birth:

Referral Source (if not Individual referred):

Referred By Name:
Referred By Address, if different than referred individual:
Referred By phone number, if different than referred individual:

☐By signing this Consent Form, you permit Presence to contact you or your representative.

Permission to Use and Disclose Confidential Information

The person whose information may be used or disclosed is:
Name:
Date of Birth:

- The information that may be disclosed includes your contact and insurance information as specified on page 1.
- This information may be disclosed to Presence Services.
- Use and disclosure of this information is permitted only as necessary for pre-enrolment evaluation and contact.
- This permission expires on **(date)**.
- I understand that this permission may be revoked.

I am the person whose records will be used or disclosed or that individual's representative.
(If personal representative, please enter the relationship).

I permit you to use and disclose my records as described in this document.

Print Name: **Signature:**
Date:

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Eligibility Documents:

- Insurance cards- front & back include primary subscriber information if different than the referred individual.
- Life plan.
- IEP (for school-aged referrals)
- Script for the PT, OT, and SLP evaluation
- The signed authorization (s) of consent to disclose PHI.

Please DO NOT LEAVE FIELD BLANK.

Please reach out as necessary by phone at 315-515-5183 or by email at info@presencedevelopmental.com

Presence