PRESENCE SERVICES REFERRAL FORM

Presence Developmental Services & Presence Counseling Services are clinician-owned and operated companies developed to provide Behavioral Support, Physical Therapy, Occupational Therapy, Speech-Language Pathology, and Social Work services to Individuals with Developmental Disabilities in the home, office, & other community locations.

Interested persons must meet the following eligibility criteria:

- Determined by OPWDD to have a developmental disability as defined in MHL 1.03(22)
- Not enrolled at a facility or program that includes the provision of the clinical services of OT, PT, SLP, psychology, or social work as part of its service model and reimbursement rates (e.g., developmental center, a specialty hospital, intermediate care facility for individuals with intellectual/developmental disabilities, etc
- Not duplicative or replaces Preschool Supportive Health services or School Supportive Health services that are authorized through an approved IEP. *However*, IPSIDD may address the service needs of preschool and school-aged children that are not addressed in the IEP and are not school-related as determined by the child's Committee on Special Education.
- Has active Medicaid

HOW TO MAKE A REFERRAL

1. Complete this referral form as completely as possible including the Permission to Use and Disclose Confidential Information Section at the end. DO NOT LEAVE ANY FIELD BLANK. Put N/A in any field not appropriate.
2. Send the completed referral form to Presence AND the required document one of the following:
   a. SECURE PATIENT PORTAL: Presence Counseling Services - Presence Developmental Services
   b. SECURE EMAIL: info@presencedevelopmental.com
   c. SECURE FAX: 315-515-5194
   d. MAIL TO: 115 Fall Street, Seneca Falls, NY 13148

Identifying Information

Name:	Date of birth:	Street Address, City & zip:
Email:	Phone:	Specify the language spoken if other than English:
Best time of day to receive contact: Morning/Afternoon/Evening	Provide copies of all insurance cards- front & back: Medicaid CIN#: Medicare #: Third-party Policy #:	Indicate any need for language/interpretation services:

Identify & Select Reason for Referral:

☐ Counseling ☐ Behavioral Support Therapy ☐ Social Sexuality Assessment & Training
☐ Occupational Therapy ☐ Speech-Language Pathology ☐ Physical Therapy

Preferred Location: ☐In-home ☐Community ☐office

Find experts. Find comfort. Find care.

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Required Documents:

- Copy of insurance card(s)
- Copy of Life plan.
- Copy of IEP (for school-aged referrals)

If referral is for Physical Therapy, Occupational Therapy, or Speech-Language Pathology include:

- Valid script for the PT, OT, and SLP referral.
- Signed authorization of consent to disclose or release PHI to
  a) Primary Care Physician
  b) School District (if school-aged)

Permission to Use and Disclose Confidential Information

By signing this Consent Form, you permit Presence Services to contact you or your representative about potential enrollment.

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.
- Theis 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 relationship_____).

I give permission to use and disclose my records as described in this document.

_____

Print Name

_____

Signature Date: