**Presence serves individuals all of ages who have received a notice of eligibility from the Office for People with Developmental Disabilities (OPWDD) and with active Medicaid insurance.**

**In addition to Medicaid, Presence accepts all insurances such as:**

* **Medicare Part B, NYS**
* **Medicaid, NYS**
* **Medicaid Advantage Plans**
* **Medicare Advantage Plans**
* **All Major Third-Party Insurance Plans**

**To be assigned a Presence provider, please complete this referral form including the Permission to Use and Disclose Confidential Information Section at the end. Please DO NOT LEAVE FIELD BLANK.**

**Select and describe the reason(s) for referral:**

Social Work Behavioral Support Therapy SocialSexuality Assessment & Training

Occupational Therapy Speech-Language Pathology Physical Therapy

**Reason (s) for the above-selected service:**

**Identify if preferred service Location:**

In-home Community office

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Referred Individual Name**:    **Email (for portal account):** | **Medicaid ID#** | **Date of birth:** | | **Current living setting**:  IRA  Community Residence  Family home  Private Residence |
| **Street Address, City & zip**: | **Phone #:**  **Best method & time of day to contact**: | **Specify the language spoken if other than English**: |
|  |  | |

* Provide copies of all insurance cards- front & back including primary subscriber information if different than the referred individual
* Copy of Life plan.
* Copy of IEP (for school-aged referrals)
* Script for the PT, OT, and SLP evaluation
* Copy of the signed authorization (s) of consent to disclose PHI.

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

## 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:**

***Our team is ready to support you!***

Submit the completed referral form **AND** all the listed eligibility documents in one of the following ways:

1. **EMAIL**: [info@presencedevelopmental.com](mailto:info@presencedevelopmental.com)
2. **FAX**: 315-515-5194
3. **MAIL TO**: 115 Fall Street, Seneca Falls, NY 13148

Please reach out as necessary by phone at 315-515-5183 or by email at [info@presencedevelopmental.com](mailto:info@presencedevelopmental.com)