Presence Referral Form for Services

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 ☐ Social Sexuality 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:	**Medicaid ID#**	**Date of birth:**	**Current living setting**: ☐ IRA ☐ Community Residence ☐ Family home ☐ Private Residence
Email (for portal account):			
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.

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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:

a. **EMAIL**: info@presencedevelopmental.com
b. **FAX**: 315-515-5194
c. **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