CENTERLIGHT Healthcare PACE

Program of All-Inclusive Care for the Elderly
Serving adults 55+

Referral Form

CL Intake (M) ID: _____

Account Rep: _____

Please complete this form and send to:
Intake Fax Number: 877-520-PACE (7223) Email: referrals@centerlight.org

POTENTIAL PROSPECT (PP) REFERRAL INFORMATION

Last Name: _____ First Name: _____

Home #: _____ Cell #: _____ Email: _____

Address: _____ Apt #: _____ City: _____ State: NY Zip Code: _____

Date of Birth: _____ Gender: ☐ Male ☐ Female SSN: _____
(must be 55 years old or over)

Current Location: ☐ Home ☐ SNF/LTC ☐ Hospital ☐ Other: _____

Lives with: ☐ Family ☐ Alone ☐ Other: _____ Language Spoken: _____

Family/Caregiver Name: _____ Relationship: _____

F/C Home #: _____ F/C Cell #: _____ F/C Email: _____

Medicaid #: _____ Needs MA: ☐ Yes ☐ No ☐ Recert. Date/Code #: _____

Medicare #: _____ Other Insurance: ☐ VA ☐ Supplemental ☐ SSDI ☐ Union Benefits
☐ No-fault ☐ Workers Comp. ☐ Group plan ☐ EPIC
☐ Retirement/Union ☐ Other _____

PP needs assistance: ☐ Bathing ☐ Dressing ☐ Meal Prep ☐ Feeding ☐ Toileting ☐ Ambulating ☐ Forgetfulness

Is the PP receiving hospice care? ☐ Yes ☐ No Was PP informed of referral: ☐ Yes ☐ No

*NYIAP CHA Assess. done? ☐ Yes ☐ No ☐ N/A *NYIAP-IPP Clinical Assess. Date: _____ ☐ No ☐ N/A

Type of case: ☐ Dual New to LTC ☐ Medicaid only (FFS) ☐ MMC ☐ Plan to Plan (PTP) _____
Plan Name

Is the PP currently receiving home care services? ☐ Yes ☐ No

If yes, vendor and services (days/hours): _____

Additional comments: _____

CDPAS? ☐ Yes ☐ No ***If yes, please complete PA information on the back form.***

PACE education completed: ☐ Yes ☐ No Initial Assessments: ☐ PP will attend Start of Care Fair ☐ IDT will make home visits

Is PP interested in attending: CLHC Day Health Center (DHC): ☐ Yes ☐ No

or other SDC: ☐ Yes, Name: _____ Location: _____ ☐ No

Mutual Case: ☐ Yes ☐ No If Yes, Name of Mutual Case: _____

PP PRIMARY CARE PHYSICIAN (PCP) (Complete worksheet in the back for more providers/medications.)

Name: _____ Phone: _____

Address: _____ Apt #: _____ City: _____ State: NY Zip Code: _____

REFERRAL SOURCE INFORMATION

Referral Source Name: _____ Date of Referral: _____

Referral Source Type: _____ Referrer Contact Name: _____

Referrer Phone: _____ Referrer Email: _____

Please complete the provider list on the back of this page. Thank you for considering CenterLight PACE! Send referrals by email to referrals@centerlight.org or fax to 877-520-PACE (7223). For questions, call us at 1-833-252-2737 or visit www.CenterLightHealthcare.org.

Last review date: 10172023

CENTERLIGHT Healthcare PACE

Prospect Worksheet

CL Intake (M) ID: _____

Potential Prospect (PP) Last Name: _____ PP First Name: _____

Doctors / Specialists / Pharmacy	Par / Non-Par	Notes
Name: _____ Phone: _____ Address: _____	☐ P ☐ NP	_____ _____
Name: _____ Phone: _____ Address: _____	☐ P ☐ NP	_____ _____
Name: _____ Phone: _____ Address: _____	☐ P ☐ NP	_____ _____
Name: _____ Phone: _____ Address: _____	☐ P ☐ NP	_____ _____
Name: _____ Phone: _____ Address: _____	☐ P ☐ NP	_____ _____
Name: _____ Phone: _____ Address: _____	☐ P ☐ NP	_____ _____

Note: Participant can also see a site PCP or an in-home provider who practice in Family Medicine, Internal Medicine, General Practice, and Geriatrics. Specialists can serve as a PCP if they provide comprehensive primary care in addition to their specialty. Types of specialists that may commonly provide primary care include cardiologists, endocrinologists, gynecologists, neurologists, rheumatologists. Certain Behavioral Health related medical specialists might also serve as PCP.

Medications (Need to be on Formulary)	Dose	Frequency	On Formulary	Notes
_____	_____	_____	☐ Y ☐ N	_____
_____	_____	_____	☐ Y ☐ N	_____
_____	_____	_____	☐ Y ☐ N	_____
_____	_____	_____	☐ Y ☐ N	_____
_____	_____	_____	☐ Y ☐ N	_____
_____	_____	_____	☐ Y ☐ N	_____
_____	_____	_____	☐ Y ☐ N	_____

Please attach additional medication information.

CDPAS Personal Assistant (PA/Aide)

Note: The PA cannot be the participant's spouse or Designated Representative/Power of Attorney.

3 Steps for CDPAS Application: (1) PA register with FI, (2) PA/PP complete CDPAS paperwork & (3) PA complete background check.

PA 1 Name: _____ Phone: _____ Email: _____

Is PA 1 Registered with Fiscal Intermediary (FI)? ☐ Yes ☐ No **FI Hire Date:** _____ Relationship to PP: _____

Identified Back-Up PA Name: _____ Phone: _____ Email: _____

Designated Rep Name (if not PP): _____ Phone: _____ Email: _____

PA 2 Name: _____ Phone: _____ Email: _____

Is PA 2 Registered with Fiscal Intermediary (FI)? ☐ Yes ☐ No **FI Hire Date:** _____ Relationship to PP: _____

PA 3 Name: _____ Phone: _____ Email: _____

Is PA 3 Registered with Fiscal Intermediary (FI)? ☐ Yes ☐ No **FI Hire Date:** _____ Relationship to PP: _____

FI employee verifying registration: _____ **FI Contact #:** _____

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