

## Requirements for New Individuals to the IPSIDD/INDEPENDENT Program:

- Life Plan (most recent existing on file.)
- Last psychological and psychosocial evals (if requesting psychology)
- Last semi & annual medical exam (if requesting nutrition)
- If Medicaid or Medicare, only provide the Medicaid number. That's all we need. We run an ePaces MEVS check!
- If duals advantage or BCBS, or Fidelis, etc. then we will need front and back of **current** card(s)
- Scripts: May be procured from the NP Visits practice or the PCP of the consumer. NT, OT and PT scripts are mandatory. Cognitive psychology and speech therapy scripts are optional.

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Multi Practitioner's Group statement:

We would appreciate the prompt completion of this packet. Please fax or mail items immediately to the assigned Intake Coordinator.

|               |                                                                                                                                                                                                                       |
|---------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Name of Group | <ul style="list-style-type: none"><li>• The Caring PT Group, PLLC</li><li>• Caring, SLP, Psychology, OT &amp; Nutrition Services, PLLC</li><li>• NP Family Health Visits &amp; NP Adult Health Visits, PLLC</li></ul> |
| Attn:         | Yvonne Pasqualicchio, Group Director                                                                                                                                                                                  |
| Address       | 17 North Plank Road, Suite 10                                                                                                                                                                                         |
| Address       | Newburgh, NY 12550                                                                                                                                                                                                    |
| Phone         | 845-800-9305                                                                                                                                                                                                          |
| Fax           | 844-800-1470                                                                                                                                                                                                          |
| Email         | Email: <a href="mailto:yp1@selectclaimsadmin.com">yp1@selectclaimsadmin.com</a>                                                                                                                                       |
| websites      | <a href="http://www.npvisits.com">www.npvisits.com</a> & <a href="http://www.caretherapygroup.com">www.caretherapygroup.com</a>                                                                                       |

## **IPSIDD/INDEPENDENT SERVICES REFERRAL FACE SHEET**

|                                                                                                    |                                                                                                                                    |
|----------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|
| <b>Name (last, first)</b>                                                                          |                                                                                                                                    |
| <b>DOB:</b>                                                                                        |                                                                                                                                    |
| <b>SSN:</b>                                                                                        |                                                                                                                                    |
| <b>Medicaid #</b>                                                                                  |                                                                                                                                    |
| <b>Medicare # (optional)</b>                                                                       |                                                                                                                                    |
| <b>Other Ins. (send copy of front and back of card)</b>                                            |                                                                                                                                    |
| <b>Full address of Treatment Location.<br/>(Specify: Group Home, Private Home, Day Hab, Other)</b> |                                                                                                                                    |
| <b>Treatment Location Contact's Name/Relationship</b>                                              |                                                                                                                                    |
| <b>Contact's best phone #</b>                                                                      |                                                                                                                                    |
| <b>Contact's email</b>                                                                             |                                                                                                                                    |
| <b>Name, email, phone of Care Manager.<br/>(Specify which CCO)</b>                                 |                                                                                                                                    |
| <b>Referred to IPSIDD program for: <input type="checkbox"/> OT Occupational Therapy</b>            | To improve impaired fine motor skills, upper extremity strength, ameliorate cognitive impairments (via ADLs, money management)     |
| <b>Referred to IPSIDD program for: <input type="checkbox"/> PT Physical Therapy</b>                | To increase endurance to gait, ambulation, stair climbing, wheelchair/walker management, upper and lower body strength             |
| <b>Referred to IPSIDD program for: <input type="checkbox"/> ST Speech Therapy</b>                  | Ameliorate effects of expressive and receptive language disorders, swallowing disorders, sign language to indicate needs and wants |
| <b>Referred to IPSIDD program for: <input type="checkbox"/> Psy Psychotherapy/Counseling</b>       | 1:1 - Cognitive (not behavioral) psychotherapy based on a Treatment Plan drawn up with input from staff, team and client           |
| <b>Logical + Social <input type="checkbox"/></b>                                                   | Psychological + Psychosocial evaluations being requested                                                                           |
| <b>Clinical Nutrition <input type="checkbox"/></b>                                                 | Meal Plans; Menu's, Recipes, LifeStyle Coaches, kitchen skills                                                                     |
| <b>eMod + DME Recommend's</b>                                                                      | Environmental Modifications + DME justifications. Wheelchairs.                                                                     |

## **CONSENT/RELEASE STATEMENT**

I am consenting to receive IPSIDD/Independent clinical services from the above Multi Practitioner Groups. I authorize any holder of medical information about me to release to the Group's Claims Administrators any information needed to determine these benefits or the benefits payable for related services.

|                                                                                                                                |  |
|--------------------------------------------------------------------------------------------------------------------------------|--|
| <b><input type="checkbox"/> Individual is unable to sign. Responsible party is completing the below on individual's behalf</b> |  |
| <b>Name of Individual or Representative</b>                                                                                    |  |
| <b>Title/Relationship to individual</b>                                                                                        |  |
| <b>Signature</b>                                                                                                               |  |
| <b>Date of consent</b>                                                                                                         |  |

# The Diabetes Prevention & Nutrition Program

Brought to you by: Caring Therapy Services!  
(via your own HIPAA compliant portal that we create for you)

1

Receive intake  
from the site

2

Intake should  
include the  
latest annual &  
semi ME

3

Evaluating RD will  
also need the latest  
height and weight of  
the Individual

4

Evaluating RD will  
call the site to  
interview Site  
Manager & Site  
Nurse

5

LifeStyle Coaches check in  
with site twice a month

- a) Beginning of the month to  
populate Weight & Wellness Grids  
and get feedback
- b) Middle of the month to deliver  
Nutrition Guidance Packets

6

Site Nurse and Staff  
– be sure to watch  
out for Cooking  
Classes video's!

**COOK WITH  
THE COOK/  
INFORMED  
INGREDIENTS!**

By working together we will make it work!



**Care Therapy Group**  
Caring & Effective