<u>Requirements for New Individuals to the IPSIDD/INDEPENDENT Program:</u>

- 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 **<u>current</u>** 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	• The Caring PT Group, PLLC • Caring, SLP, Psychology, OT & Nutrition Services, PLLC • NP Family Health Visits & NP Adult Health Visits, PLLC
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: yvonnep@selectmulticare.com
website	www.selectmulticare.com
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IPSIDD/INDEPENDENT SERVICES REFERRAL FACE SHEET

Name (last, first)	
DOB:	
SSN:	
Medicaid #	
Medicare # (optional)	
Other Ins. (send copy of front and back of card)	
Full address of Treatment Location. (Specify: Group Home, Private Home, Day Hab, Other)	
Treatment Location Contact's Name/Relationship	
Contact's best phone #	
Contact's email	
Name, email, phone of Care Manager. (Specify which CCO)	
Referred to IPSIDD program for: □ OT Occupational Therapy	To improve impaired fine motor skills, upper extremity strength, ameliorate cognitive impairments (via ADLs, money management)
Referred to IPSIDD program for: □ PT Physical Therapy	To increase endurance to gait, ambulation, stair climbing, wheelchair/walker management, upper and lower body strength
Referred to IPSIDD program for: □ ST Speech Therapy	Ameliorate effects of expressive and receptive language disorders, swallowing disorders, sign language to indicate needs and wants
Referred to IPSIDD program for: □ Psy Psychotherapy/Counseling	1:1 - Cognitive psychotherapy based on Treatment Plan drawn up with input from staff, team and client; Behavior Plans
Logical+Social/Adaptive+Cognitive □	Psychological + Psychosocial evaluations being requested
Clinical Nutrition/Eating Disorders □	Meal Plans; Menu's, Recipes, LifeStyle Coaches, kitchen skills
eMod + DME Recommend's □	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.

❑ **Individual is unable to sign. Responsible party is completing the below on individual's behalf**	
Name of Individual or Representative	
Title/Relationship to individual	
Signature	
Date of consent	

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

WheelChair Clinic Services at home!

1. You tell us whom is need of a new or a re-newed wheelchair
2. Our Nurse Practitioners will issue the order for the WC
3. We will come to your home or group home to do the measurements. We gladly accept staff and patient's input. After all, you are the ones using and assisting the use of this wonderful new WC
4. We are in liaison with a trustworthy WC vendor who will be accompanying us on day 2 of the assessment and report
5. After the WC arrives at your home, our Nurse Practitioners will conduct a post-delivery Q&A

ENJOY YOUR NEW CHAIR!

Brought to you by Caring Therapy Services, PLLC and NP Visits, PLLC

Requirements for WheelChair Clinic Services:

- Last WC Report or Post Arrival QA Report (if replacement being requested)
- If Medicaid or Medicare, only provide the Medicaid number. That's all we need. We run an ePaces MEVS check!
- If dual advantage or BCBS, or Fidelis, etc. then we will need front and back of **current** card(s)
- Referral Rx for WC. Will be done through the NP Visits practice

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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 Groups	• Caring OT, PT, SLP & Nutrtition Services, PLLC • NP Family Health Visits & NP Adult Health Visits, PLLC
Attn:	Errol Mais, Site Coordinator
Address	17 North Plank Road, Suites 10A & 10B
Address	Newburgh, NY 12550
Phone	845-800-9305
Fax	844-800-1470
Email	ErrolM@selectmulticare.com
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WHEELCHAIR CLINIC SERVICES REFERRAL FACE SHEET

Name (last, first)	
DOB:	
SSN:	
Medicaid #	
Medicare # (optional)	
Other Ins. (send copy of front and back of card)	
Full address of WC Assessment Location	
WC Assessment Location Contact's Name/Relationship	
Contact's best phone #	
Contact's email	
Name, email, phone of Care Manager. (Specify which CCO)	
Referred for WheelChair Clinic Services	☐ New Wheelchair ☐ Replacement Wheelchair

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.

❑ **Individual is unable to sign. Responsible party is completing the below on individual's behalf**	
Name of Individual or Representative	
Title/Relationship to individual	
Signature	
Date of consent	

GROUP HOME CASELOAD GRID

Res Mgr		Multi Prac Group	Caring Therapy Services, PLLC
Phone		Community Agency	
Fax		Group Home Address	
Alt/Addt'l Contact		Email for site contact	

INDIVIDUAL (Last, First name)	**MEDICAID #**	**Speech** Therapy	**Physical** Therapy	**Occupational** Therapy	**Psychotherapy** (Treatment Plans; Behavior Plans)	**Nutrition** (Diabetes; Eating disorders; Prader-Willi)	**WheelChair Clinic Services** (measurements & reports)
Doe, Sample	AA22222B	X	X	X	X	X	X

The referrals here were agreed upon by the CareTaking Team of the Group Home

Comments:_____

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