

## 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: yvonnep@selectmulticare.com                                                                                                                                                                                    |
| website       | <a href="http://www.selectmulticare.com">www.selectmulticare.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/ABA</b>   | 1:1 - Cognitive psychotherapy based on Treatment Plan drawn up with input from staff, team and client; ABA                         |
| <b>Logical+Social/Adaptive+Cognitive <input type="checkbox"/></b>                                  | Psychological + Psychosocial evaluations being requested                                                                           |
| <b>Nutrition/Eating Disorders <input type="checkbox"/></b>                                         | Meal Plans; Menu's, Recipes, LifeStyle Coaches, kitchen skills                                                                     |
| <b>eMod. vMod. Wheelchairs. DMEs. <input type="checkbox"/></b>                                     | Clinical Justifications provided by skilled clinicians                                                                             |

## **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> |  |
| 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**

### 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) | eMod. vMod. WheelChair. Other DME clinical justification |
|-------------------------------|------------|----------------|------------------|----------------------|-------------------------------------------------|------------------------------------------------------|----------------------------------------------------------|
| Doe, Sample                   | AA22222B   | X              | X                | X                    | X                                               | X                                                    | X                                                        |
|                               |            |                |                  |                      |                                                 |                                                      |                                                          |
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|                               |            |                |                  |                      |                                                 |                                                      |                                                          |

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

Comments: \_\_\_\_\_

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