GSNY Home Care Services Inc.

Serving: Brooklyn, Queens, Bronx, Staten Island, Manhattan, Long Island, Westchester

PH: (347) 577-9093 **office@gsnyhcsi.com** **FAX: (347) 579-0099**

Please call if you have any questions or need more information. To make a referral, please fill out this form as completely as possible and **fax to: 1-347-579-0099 or email to: office@gsnyhcsi.com**

REQUIRED INFORMATION

NAME OF PATIENT: (First) _____(Last) _____

PHONE:_____ **MEDICAID #**: _____

REFERRAL TYPE: ❑**LHCSA (PCA/HHA)** ❑**CDPAP** ❑**Private Pay** ❑Community/Other

Is this patient aware of this referral? ( ) Yes ( ) No **LANGUAGE SPOKEN**:_____

REFERRED BY:_____REFERRER PHONE:_____

ORGANIZATION:_____Date of Referral: _____

PATIENT INFORMATION

PATIENT ADDRESS: _____

Date of Birth:_____SS#:_____Gender: ❑**M** ❑**F** Marital Status: ❑**S** ❑**M** ❑**W**

Current Location: ❑Home ❑Alone ❑With family ❑Nursing Facility ❑Hospital ❑Other: _____

Medicaid Status: ❑Eligible #_____❑May be eligible ❑Medicare # _____

Other Insurance #:_____

FAMILY/CAREGIVER CONTACT INFORMATION

NAME:_____RELATIONSHIP TO PATIENT: _____

Address (if available): _____

Phone (if available): _____

REASON FOR REFERRAL

❑Chronic conditions ( ) Yes ( ) No _____

❑Disabilities ( ) Yes ( ) No _____

❑Requires assistance ( ) Yes ( ) No (e.g. skilled nursing, home care, personal care)

Primary Diagnosis (if known): _____

_____

ENROLLMENT TYPE: ❑New to MLTC ❑Plan to Plan Transfer

Additional Information _____

_____

PATIENT'S PRIMARY CARE PHYSICIAN (if known)

Name:_____ Signature:_____

Address:_____ Phone:_____