archcare
The Continuing Care Community of the Archdiocese of New York

ArchCare Senior Life PACE Referral

E-FAX 646-304-7131 or SECURELY EMAIL ARCHCAREPACEREFERRALS@archcare.org

ArchCare Care Member / Marketing Rep / Community Referral Contact: Cheryl Sanchez (646) 901-3884	
Referring Organization/Practice Name:	Date Referred:
Referrer Name:	Phone:
PCP Name (if different):	Phone:

Name of Patient: _____ Home/ Cell Phone/: _____
First Name Last Name Alternate Number

Address: _____ Apt: _____

City, State, Zip: _____

DOB: _____ Gender: ☐ Male ☐ Female SSN#:_____

Medicaid/CIN#:_____Medicare/MR#_____

SSN# & Medicaid/CIN# required for PACE referrals

Primary language spoken/read: _____ Participant can make own decisions: ☐ Yes ☐ No

Current Location: ☐ Home ☐ Nursing Home* ☐ Hospital* ☐ Assisted Living Program* ☐ Adult Home*
☐ Short Term Rehab* ☐ Long Term Care* ☐ Other: _____
*Name of Institution: _____

Diagnosis/Clinical Info:

_____

_____

Lives with: ☐ Alone ☐ Family ☐ Nursing Home ☐ Other: _____	
Family / Caregiver Name:_____	Relationship: _____
Address: _____	City, State, Zip: _____
Home / Cell Phone:_____	Other: _____

Referral Form Attestation

I, _____ attest this client was informed of this referral and agrees to be called by ArchCare to receive information on their health plans.

Signature: _____ Date: _____
*By typing your name in the "Signature" space, you are electronically signing this document.