

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: First Name Last Name	
Address: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: \square Yes \square 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.	