archcare
The Continuing Care Community of the Archdiocese of New York

ArchCare PACE Referral Form

Please fill out this form as completely as possible and send to enroll@archcare.org or fax to **(646) 304-7131**.

You may also call us at **1-866-670-5858** M-F, 8:30AM-5:00PM.

Available Date:_____; Time:_____ to discuss PACE program.

ArchCare Account Manager/Referral Contact:_____

Referral Source Information:

Referral Source Name: _____ Referral Date: _____

Referral Source Type:_____Referrer Contact Name:_____

Referrer Phone:_____Referrer Email:_____

Prospect Information:

Name of Prospect: _____ Home/Cell #_____

Address: _____ Apt. #: _____

City, State, Zip Code: _____ Language: _____

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

Medicaid/CIN#:_____ Needs assistance with Medicaid: ☐ Yes ☐ No

Medicare/MR#: _____ Other Insurance: _____

NYIA Date: _____ PO Date: _____ Current Services: ☐ Home Care ☐ CDPAS

Current Location: ☐ Home ☐ SNF/ LTC* ☐ Hospital* ☐ Assisted Living Program* ☐ Adult Home ☐ SRO ☐ Convent ☐ Other: *Name of Institution: _____

Lives with: ☐ Alone ☐ Family ☐ Other _____

Diagnosis/ Clinical Info:_____

Family/Caregiver Information:

Family/Caregiver Name :_____Relationship:_____

Home/ Cell#: _____ Email: _____ Can Assist Translate: ☐ Yes ☐ No

Legal Guardian:_____Home/ Cell#:_____

Primary Care Provider (PCP) Information:

Name:_____Phone: _____

Address:_____Suite#:_____City:_____State, NY Zip_____

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.

Form updated: 07/10/2023