Kalos Health

716-304-1212

www.KalosHealth.org

ENROLLEE NAME:	**DATE OF REFERRAL:**
MEDICAID ID (OR SS#):	**REFERRING CONTACT:**
ENROLLEE DOB:	**REFFERRING AGENCY:**
ENROLLEE PHONE:	**CONTACT NUMBER:**
ENROLLEE ADDRESS:	

ADDITIONAL INSURANCES

Include Medicare, MCO, Mainstream Medicaid, Other MLTCP if transferring and any additional insurances known:

Please Note: Some Insurances may prevent a referral from being able to enroll into our MLTC Plan

CORE SERVICE NEED

Referral must have a need for at least 1 of the following Core Services for 120 days or more per year. Check All That Apply:

	Home Care (HHA, PCA, Nursing, OT, PT, ST)
	Adult Day Health Care (Medical Day)
	CDPAS (Consumer Directed Personal Aid Service)
	Long Term Nursing Home Placement

RESTRICTIONS

IF REFERRAL HAS ANY OF THE FOLLOWING, THEY MAY NOT BE ELIGIBLE FOR MLTC SERVICES.

Please Call if you have additional questions

If the referral is currently being treated in a hospital, facility operated by the State Office of Mental Health (OMH), Office of Alcoholism and Substance Abuse (OASAS), Office for People with Developmental Disabilities (OPWDD), Traumatic Brain Injury Waiver Program (TBI Waiver), Nursing Home Transition & Diversion Waiver (NHTD Waiver) or an Assisted Living Program (ALP).

ADDITIONAL NOTES:

*****PLEASE NOTE: THIS REFERRAL DOES NOT GUARNTEE ENROLLMENT*****

Please Fax Referral to 716-731-2013