



INSTRUCTIONS

Please fill out the below information to the best of your knowledge. Once complete, **please send via secure email (encrypted) to: enrollment@kaloshealth.org** ; our enrollment department will follow up with the referral within 48 business hours of receiving the form. If you have any questions or concerns, **please feel free to call 716-304-1212 for further assistance.**

| | | | |
|-----------------------------|--|---------------------------|--|
| Enrollee Name: | | Date of Referral: | |
| Medicaid # (or SSN): | | Referring Contact: | |
| Enrollee DOB: | | Referring Agency: | |
| Enrollee Phone: | | Contact Number: | |
| Enrollee Address: | | Agency Email: | |

| CORE SERVICE NEED | | ADDITIONAL INFORMATION | |
|--|--|---|--|
| 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: | | <input type="checkbox"/> NYS Conflict Free Evaluation <input type="checkbox"/> Currently in another MLTC program <input type="checkbox"/> None of the Above | |
| <input type="checkbox"/> Home Care (HHA, PCA, Nursing, OT, PT, ST) <input type="checkbox"/> Adult Day Health Care (Medical Day) <input type="checkbox"/> CDPAS (Consumer Directed Personal Aid Service) <input type="checkbox"/> Long Term Nursing Home Placement | | CONTACT INFORMATION | |
| | | Name: | |
| | | Relationship: | |
| | | Contact Number: | |

Please use the space below for any additional questions or comments

RESTRICTIONS

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

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).

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