Kalos Health

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

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

ADDITIONAL INFORMATION

	NYS Conflict Free Evaluation
	Currently in another MLTC program
	None of the Above

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 GUARNTEE ENROLLMENT*****