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icircle Care

Pre-Enrollment Referral Form

icircle Care is a NYS Approved Medicaid Managed Long-Term Care Plan that assists people who are chronically ill or disabled and require health and long-term care services through administration of home care, personal care, social supports, transportation, and/or skilled nursing facility services. iCircle Care coordinates all services for their members, including visits to physicians and hospital admissions. Interested persons who meet the following criteria are encouraged to complete a Pre-Enrollment Referral form to receive information on how to enroll in icircle Care:

- Is eighteen (18) years of age or older;
- Lives in one of the following service counties: Allegany, Broome, Cattaraugus, Cayuga, Chautauqua, Delaware, Erie, Herkimer, Madison, Monroe, Niagara, Oneida, Onondaga, Orleans, Oswego, Wayne, Chemung, Chenango, Cortland, Otsego, Schuyler, Steuben, Tioga, Tompkins, Genesee, Livingston, Ontario, Seneca, Wyoming, or Yates
- Has active Medicaid or qualifies for Medicaid.

❍ **I would like to receive information on the icircle Care Medicaid Managed Long Term Care plan.**

How to Make a Pre-Enrollment Referral:

1. Complete this referral form as completely as possible including the **Permission to Use and Disclose Confidential Information section on the back side of this form.**
2. Send completed referral form to icircle Care via one of the following:
   a. **Secure Email**: enrollment@icirclecarecny.org
   b. **Secure Fax**: 1-888-519-2816
   c. **Mail to**: 860 Hard Road, Webster, NY 14580 Attn: Enrollment Coordinator

Identifying Information Required:

Name:	**Date of Birth:**	**Gender: M F**
Street Address:	**SS#:**	
	Medicaid CIN#:	
City, State Zip:	**Medicare (MBI)#:**	
	County of Residence:	
Phone:	**Email:**	
Health Care Proxy / Alternative Contact(s) Name & Phone#:		
PCP Name:	**PCP Phone:**	
Indicate any need for language/interpretation services; specify language spoken if other than English:		

Best Way to Receive Information: ☑ by Phone ☑ by Mail ☑ by Email: (email address: _____
Best Time of Day to Receive Contact: ☑ Morning ☑ Afternoon ☑ Evening
Reason for Referral: ☑ Aide Service ☑ Adult Day Program ☐ Nursing Services ☑ PT/OT/Speech ☑ Other:

Contact Information for Person Completing Referral

Name:	**Title:**
Organization:	
Referring Mailing Address:	**City, State Zip:**
Phone:	**Email:**

Permission to Use and Disclose Confidential Information

By signing this Consent Form, you permit icircle Care to contact you or your representative about potential enrollment in it's program.
The person whose information may disclosed is:

Name: _____

Date of Birth: _____

- The information that may be disclosed includes your contact and insurance information as specified on page 1.
- This information may be disclosed to icircle Care.
- Use and disclosure of this information is permitted only as necessary for the purposes of pre-enrollment evaluation and contact.
- This permission expires on: _____ (date).
- I understand that this permission may be revoked. I also understand that records disclosed before this permission is revoked may not be retrieved.

I am the person whose records will be used or disclose, or that individual's personal representative.

I give permission to use and disclose my records as described in this document.

Print Name: _____

Signature: _____ **Date:** _____