



**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, Chemung, Chenango, Cortland, Delaware, Erie, Herkimer, Madison, Monroe, Niagara, Oneida, Onondaga, Ontario, Orleans, Oswego, Wayne, Otsego, Schuyler, Steuben, Tioga, Tompkins, Genesee, Livingston, 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 below**
2. Send completed referral form to iCircle Care via one of the following:
  - a. **Secure Email:** [enrollment@icirclecarecny.org](mailto:enrollment@icirclecarecny.org)
  - b. **Secure Fax:** 1-888-519-2816
  - c. **Mail to:** 860 Hard Road, Webster, NY 14580 Attn: iCircle Care Enrollment Coordinator

**Identifying Information**

Name:			Date of Birth:	Gender: M   F
Street Address:			SS#:	
			Medicaid CIN #:	
City	State	Zip	Medicare # <input type="checkbox"/> Part A <input type="checkbox"/> Part B	
			County of Residence:	
Phone:			E-Mail:	
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 E-mail: (E-mail Address: \_\_\_\_\_)

Best time of day to receive contact:

Morning    Afternoon    Evening

Reason for Referral:

**Contact Information for Person Completing Referral:**

Name:	Title:
Organization:	Address:
Phone:	E-Mail:

**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 its program.

The person whose information may be used or 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 disclosed, or that individual's personal representative. (If personal representative, please enter relationship \_\_\_\_\_.)

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

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date