HAMASPIK MEDICARE CHOICE (MAP) REFERRAL FORM

Form can be sent via fax or Email: enroll@hamaspikchoice.org

Direct Phone: 888-426-2774; Extension: 605; Direct Fax: 845-503-1546

Date of Referral:	**Referral Source Contact Info: Name: _____ Agency: _____** **Phone: _____ Fax:_____ Email: _____**

APPLICANT INFORMATION				
Last Name:	**First Name:**		**DOB:**	
Primary Language(s) (if not English):				
Home Phone:	Cell Phone:		Best time to contact:	
Street:	Apt:	City:	State:	Zip Code:

Home Care Information	
Did Applicant have Maximus (CFEEC) assessment?	Yes: ☐ Date: _____ No: ☐
Is client currently receiving homecare services?	Yes: ☐Details: _____No: ☐
Indicate which service client would like to receive:	CDPAS: ☐ PCA: ☐ DOH 4359 attached: Yes: ☐ No: ☐

HEALTH INSURANCE	
Medicaid #:	Other health insurance(s) as applicable:
Medicare #:	
Is Client currently enrolled in a managed care plan?	Yes: ☐ Name of Plan: _____ No: ☐

CAREGIVER/EMERGENCY CONTACT INFORMATION		
Name (1):	Relationship:	Phone #
Name (2):	Relationship:	Phone #

PHYSICIAN INFORMATION If the individual has multiple specialists, please add to the second sheet.	
PCP Name/Group:	**PCP Phone | Fax:**
Address:	**NPI:**
Specialist(s) Name/ Group:	**Phone | Fax:**
Address:	**NPI:**
Additional Information:	
Signature for Consent to Contact (Optional): _____	

MAP REFERRAL- ADDITIONAL PHYSICIAN INFORMATION

ADDITIONAL PHYSICIAN INFORMATION	
Specialist(s) Name/ Group:	**Phone | Fax:**
Address:	**NPI:**
Specialist(s) Name/ Group:	**Phone | Fax:**
Address:	**NPI:**
Specialist(s) Name/ Group:	**Phone | Fax:**
Address:	**NPI:**
Specialist(s) Name/ Group:	**Phone | Fax:**
Address:	**NPI:**
Specialist(s) Name/ Group:	**Phone | Fax:**
Address:	**NPI:**