

The Capital Region's only Program of All-Inclusive Care for the Elderly (PACE)

SCREENING FOR ELIGIBILITY (all must apply)

<input type="checkbox"/>	Age 55 or older	<input type="checkbox"/>	Qualify for long-term care services > than 120 days
<input type="checkbox"/>	Live within zip code service area (see lists at bottom)	<input type="checkbox"/>	Able to live safely in the community

REFERRAL FORM

Please complete this form to the best of your ability and send to Eddy SeniorCare (see below)

Referral Information			
Date of referral:		Agency making referral (if any):	
Name of person making referral:		Phone:	Email:
Recipient's Information			
Name of Referral:			DOB:
Address:			
Phone Number:			
Current Living Situation:	<input type="checkbox"/> House/Apt <input type="checkbox"/> Senior Housing <input type="checkbox"/> Homeless <input type="checkbox"/> Unknown <input type="checkbox"/> Nursing Home (Name):		
Name of Contact Person (if different from Recipient):	Relationship:	Phone:	Email:
Insurance Information Please provide as much info as possible/leave blank if unknown			
Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown ID # (if enrolled/known):	Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown ID # (if enrolled/known):		
MLTC Program: <input type="checkbox"/> No <input type="checkbox"/> Yes Name: HC Provider: # Hrs/Wk:	3rd Party Health Ins Co: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Name (if known):		
Medical Diagnoses Please provide as much info as possible/leave blank if unknown			
Reason for Referral Check all that apply, if known			
<input type="checkbox"/> Inadequate social/family support	<input type="checkbox"/> Cognitive issues/Dementia		
<input type="checkbox"/> Inadequate engagement with healthcare system or current provider	<input type="checkbox"/> Difficulty with activities of daily living (e.g., dressing, eating)		
<input type="checkbox"/> Difficulty managing treatment(s) or medication(s)	<input type="checkbox"/> Repeated recent hospitalizations or ER visits for preventable conditions		

Referrals for either location can be sent to: FAX (518) 375-3709 or Email: SPNYPaceIntake@sphp.com

<u>Schenectady PACE Center:</u>	<u>Latham PACE Center:</u>
1938 Curry Road Rotterdam, NY 12303	385 Watervliet-Shaker Road Latham, NY 12110
Email: Tammie.Santilli@sphp.com or call: 518-382-3290	Email: Amy.Schnellbaecher@sphp.com or call: 518-213-7526
<u>Service Areas By Zip Code:</u>	<u>Service Areas By Zip Code:</u>
Schenectady/Albany Counties: 12008, 12150, 12302, 12303, 12304, 12305, 12306, 12307, 12308, 12309, or 12205 N/W of New Karner Rd/Rt 155	Albany/Rensselaer Counties: Albany in 12047, 12110, 12183, 12189, 12202, 12203, 12204, 12205, 12206, 12207, 12208, 12209, 12210, or 12211; Rensselaer in 12061, 12144, 12180 south of Route 278, or 12182 S/W of Irish Rd

Thank you for your referral!