maximus

NEW YORK PASRR REFERRAL INTAKE FORM

Include this completed form as the first page of your Level II referral following the fax coversheet. All fields are required.

Required documents: Intake form, H&P, PRI, SCREEN

Return this content to Maximus: ***877.431.9568.***

Print legibly to prevent delays. Outcomes will be **faxed 5 business days** from receipt of necessary information.

Individual's Full Legal Name: _____ Date of Birth: _____
First Last

Individual's Mailing Address: _____
Street City

_____
County Zip

Social Security Number: _____ M _____ Gender: _____

Race: _____ Primary Language: _____ Translation Services Needed: ☐ Yes ☐ No

Individual's Current Location: _____ Date of Admission: _____

Current Location Type:
☐ Community Setting
☐ Medical facility medical unit
☐ Medical facility ER/ED
☐ Medical facility psychiatric unit
☐ Psychiatric facility
☐ Nursing facility
☐ Other

Location Address: _____
Street City State Zip

Location Phone: _____

Method of Payment
☐ Self-Pay
☐ Medicare
☐ Medicaid
☐ Private Insurance
☐ Medicaid Pending

Medicare ID Number # _____

Medicaid ID Number # _____

Legal Guardian: ☐ Yes ☐ No

Legal Guardian is a court appointed representative. Do not include next of kin or POA.

Legal Guardian Name: _____ Legal Guardian Phone Number: _____

Legal Guardian Address: *(required if applicable)* _____
Street City State Zip

Primary Care Physician: _____ ☐ N/A Physician Phone Number: _____

Physician Address: *(required if applicable)* _____
Street City State Zip

Referral Organization/Facility Name: _____

Referral First and Last Name: _____ Referral Email: _____

Referral Phone Number: _____ Referral Fax Number: *Outcomes will be faxed to this number* _____

Review Type: ☐ Preadmission ☐ Status Change/Resident Review **Indicate reason below:**

☐ Psychiatric Hospitalization
☐ Change in psychiatric diagnosis(es)
☐ Increase in behavioral health symptoms
☐ Improvement in functional status
☐ Other (specify): _____