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 below**

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: iCircle Care Enrollment Coordinator

Identifying Information

<table>
<tr><td colspan="3">Name:</td><td>Date of Birth:</td><td>Gender: M F</td></tr>
<tr><td colspan="3" rowspan="2">Street Address:</td><td colspan="2">SS#:</td></tr>
<tr><td colspan="2">Medicaid CIN #:</td></tr>
<tr><td>City</td><td>State</td><td>Zip</td><td colspan="2">Medicare #
☐ Part A ☐ Part B</td></tr>
<tr><td colspan="3">Phone:</td><td colspan="2">County of Residence:
E-Mail:</td></tr>
<tr><td colspan="5">Health Care Proxy/Alternative Contact(s) Name, Phone #:</td></tr>
<tr><td colspan="3">PCP Name:</td><td colspan="2">PCP Phone:</td></tr>
<tr><td colspan="5">Indicate any need for language/interpretation services; specify language spoken if other than English:</td></tr>
</table>

Best way to receive information: ☐ By Phone ☐ By Mail ☐ By E-mail: (E-mail Address:_____)
Best time of day to be contacted: ☐ Morning ☐ Afternoon ☐ Evening
Reason For Referral:
How Did You Hear About iCircle? ☐ Website / Internet Search ☐ Provider Relations Team ☐ County / NYS Medicaid Resources ☐ Provider Referral (Name of Provider:_____) ☐ iCircle Presentation (Please Specify: _____) ☐ Other (Please Specify: _____)

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 name and relationship _____.)

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

_____
Print Name

_____ _____
Signature Date