



VCS MENTAL HEALTH CLINIC

Referral for Services

Fax form to VCS at (845) 634-7839 or email to ilaidlaw@vcs-inc.org

CLIENT DATA: (All information is confidential)

Please print clearly

Name: _____

Social Security #: _____ Date of Birth: _____

Phone #: _____

Address (Street & Number): _____

Address (City, State, Zip): _____

Parent / guardian name (if applicable): _____

School name (if child / adolescent): _____

Reason for Referral: _____

Plan for transportation to appointment in place (required)? Yes No

Details:

REFERRING AGENCY:

Contact Name: _____

Agency Name: _____

Contact Phone #: _____ Contact Fax#: _____

Contact Email Address: _____

INSURANCE INFORMATION:

Medicaid Yes No Policy Number: _____

Medicaid Managed Care: Fidelis Affinity
 MVP Empire BCBS HealthPlus
 Affinity Healthfirst
 United Healthcare Wellcare
 Crystal Run Healthplan
Policy Number: _____

Family Health Plus? Yes No FHP#: _____

Other Insurance Yes No

Insurance Name: _____ Insurance ID#: _____

Phone # (from back of the id card): _____ Group # _____

Insured's Name: _____ Insured's DOB: _____

Relationship to Client: _____

Insured's Address: _____

Insured's Social Security #: _____