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: _____ Phone #: _____

Social Security #: _____ Date of Birth: _____

Email (required for telehealth sessions): _____

Language fluency (check all that apply): ☐ English ☐ Spanish ☐ Creole

Address (Street & Number): _____

Address (City, State, Zip): _____

Parent / guardian name (if applicable): _____

Language fluency (check all that apply): ☐ English ☐ Spanish ☐ Creole

School name (if child / adolescent): _____

Reason for Referral: _____

_____

_____

_____

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

Details: _____

Preference for services: ☐ In person ☐ Telehealth Video ☐ Telehealth Phone

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 □ Aetna

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 #: _____