VCS MENTAL HEALTH CLINIC
Referral for Services

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

CLIENT DATA: ***(All information is confidential)*** **Please print clearly**

Name: ______________________________

Social Security #: ______________ Date of Birth: ______________

Phone #: ______________

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: ______________________________

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

Details:

REFERRING AGENCY:

Contact Name: ______________________________

Agency Name: ______________________________

Contact Phone #: ______________ Contact Fax#: ______________

Contact Email Address: ______________________________

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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 #: ____________________

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