VCS MENTAL HEALTH CLINIC
Referral for Services

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

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

Name: _____ Phone #: _____

Date of Birth: _____ Email: _____

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

Please check off if the individual being referred is a student at the following schools and is interested in receiving psychotherapy at our school-based clinics:

◯ Haverstraw Elementary School ◯ Kakiat STEAM Academy ◯ Pomona Middle School
◯ Ramapo High School ◯ Spring Valley High School

REFERRING AGENCY:

Contact Name: _____

Agency Name: _____

Contact Phone #: _____ Contact Fax#: _____

Contact Email Address: _____

INSURANCE INFORMATION:

Medicaid ☐ Yes ☐ No ID Number: _____

Medicaid Managed Care: ☐ Fidelis ☐ Affinity by Molina

☐ MVP ☐ Empire BCBS HealthPlus

☐ Healthfirst ☐ United Healthcare

Policy Number: _____

Child/Family Health Plus ☐ Yes ☐ No FHP#: _____

Medicare Number: _____

*Please note that we are unable to accept commercial Medicare plans (other than Fidelis and MVP) but we can accept clients with dual coverage Medicare-Medicaid.

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: _____

***Please include a copy of supporting documentation, such as a psychiatric evaluation, psychosocial assessment, treatment plan, or recent progress notes. Thank you.**