## VCS MENTAL HEALTH CLINIC Referral for Services

Fax form to VCS at (845) 634-7839 or email to referrals@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 i	in place (required)? ☐ Yes	□ No	
Details:			
Preference for services: ☐ In personal In personal In personal In personal Interested in receiving psychotherapy a ☐ Kakiat STEAM Academy ☐ Ramapo High School ☐ ☐	referred is a student at the foll t our school-based clinics:	owing schools a	nd is

REFERRING AGENCY:		
Contact Name:		
Agency Name:		
Contact Phone #:	Contact Fax#:	
Contact Email Address:		
INCUDANCE INFORMATION:		
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 FH	P#:	
Medicare Number:		
*Please note that we are unable to accept comme	rcial Medicare plans (other than Fidelis, MVP,	
and UHC) but we can accept clients with dual cover	erage Medicare-Medicaid.	
Other Insurance ☐ Yes ☐ No		
Insurance Name: I	nsurance ID#:	
Phone # (from back of the id card):		
Insured's Name:	Insured's DOB:	
Relationship to Client:		
Insured's Address:		
*VCS participates in Fidelis, MVP, and UHC (inclu-	ding Optum/Oxford/Oscar) commercial plans.	

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