QUEENS CENTERS FOR PROGRESS
81-15 164th Street, Jamaica, NY 11432
718-380-3000, Ext. 269 & 335
Qcpclinic@queenscp.org

ARTICLE 16 CLINIC REFERRAL FORM

Date: ____/____/____

Have you been seen here before? ☐ Yes ☐ No If so, when? _____

Do you have an OPWDD TABS number? ☐ Yes ☐ No If so, please indicate: _____

Individual Information:

Name: _____ Gender: ☐ M ☐ F ☐ Other, please specify: _____

DOB: ____/____/____ Social Security #: _____-_____-_____ Primary language: _____

Address: _____ City: _____ State: NY Zip: _____
(include apartment/unit number) (if not located in Queens, please call before sending)

Residence Type: ☐ Private ☐ ICF ☐ IRA ☐ Supp. Apt/SRO ☐ Other, please specify: _____

Is individual ambulatory? ☐ Yes ☐ No If not, how do you ambulate? _____

Primary diagnosis (if known): _____

Advocate Information:

Name: _____ Relation to Individual: _____

Primary language: _____ Same address as individual? ☐ Yes ☐ No (please fill below)

Address: _____ City: _____ State: NY Zip: _____
(include apartment/unit number)

Main phone #: _____-_____-_____ Alternate #: _____-_____-_____ Alternate #: _____-_____-_____

E-mail address:_____

Referring Information:

Name: _____ Title: _____ Agency: _____

Address: _____ City: _____ State: NY Zip: _____
(include suite/unit number)

Main phone #: _____-_____-_____ Alternate #: _____-_____-_____ Alternate #: _____-_____-_____

E-mail address:_____ Relation to individual: _____

Payment Method:

Medicaid #*: _____ Medicare #: _____ Private/Commercial: _____

*(If you do not have Medicaid at this time, **AND** do not live in Queens **OR** have OPWDD Eligibility, please call before sending)

Requested Clinical Services:

☐ Psychological Evaluation (Date of **last** psychological evaluation if applicable: ____/____/____)

☐ Psychosocial Evaluation (Date of **last** psychosocial evaluation if applicable: ____/____/____)

☐ *Psychosexual Assessment

*Must be at least 18 years old and have OPWDD Care Manager

☐ **17-A Guardianship Affidavit of Examining Licensed Psychologist

You **MUST be working with a lawyer or entity that will assist you with your 17-A Petition for Guardianship

☐ ***Autism Testing

*** You **MUST** include official letter from OPWDD requesting this testing

☐ Other, please specify: _____

Reason for Requested Service: _____

Requested Programming:

☐ QCP's Bellerose Day Habilitation Program

☐ QCP's 164th Street Day Habilitation Program

☐ QCP's Community Prevocational Program

☐ QCP's Supported Employment Program

☐ QCP's Residential Program

Required Documents:

(*must be included in order to process referral)

*Insurance information: Medicaid, Medicare and private/commercial insurance cards

*Identifying documentation: Social Security card, birth certificate and/or Resident Alien Card (if not a citizen)

*School reports: IEP, psychoeducational, psychosocial history

*Care Coordination related documents (if enrolled in ACA, Care Design NY or TriCounty Care): Life Plan, previous psychological and/or psychosocial evaluations

-Medical documents: Annual medical or recent medical reports

-Additional medical and clinical evaluations if available: Neurological, neuropsychological, etc.

Before Sending:

-Ensure all fields are completed

-Reason for requesting services is clear

-Attach all required documents

When ready, send all documents to Qcpclinic@queenscp.org. We will confirm receipt within 24 hours.

Office Use Only:

MD Approval: _____ ____/____/____