Future Care Planning Services Referral

Date: _____

Care Coordination Agency (or other provider): _____

Care Coordinator/Social Worker: _____

Address: _____

Phone: _____

Fax: _____

Email: _____

Person w/ Disability: _____ Age: _____ DOB: _____

Disability Diagnosis: _____

OPWDD Eligible: ___Yes __ No if Yes, TABS ID: _____

Medicaid #: _____

Caregiver name: _____

Caregiver address: _____

Caregiver phone: _____

Email: _____

Desired Planning Outcomes: _____

The referral may be scanned and emailed, mailed, or faxed to our office:

Future Care Planning Services
1000 Elmwood Avenue
Rochester, New York 14620
erosato@futurecareplanning.org
Fax: 585-210-4048
Office: 585-402-7840 ext. 5

If OPWDD eligible, please include a copy of the Life Plan, current psychological evaluation, OPWDD NOD or HCBS Waiver NOD, and if doing self-direction, a copy of the budget summary sheet or expense report.