Mail or fax completed application with required documentation to:
Arc of Onondaga - Horizons Article 16 Clinic
600 South Wilbur Avenue, Syracuse, NY 13204
Fax #: 315-476-1582
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For more information, contact the Treatment Coordinator at
315-476-7441 x1111 ~ HorizonsIntake@arcon.org

# Horizons Article 16 Clinic Application

***(Please type or print clearly)***

**Applicant's Name:** ________________________ TABS ID: ____________

Address: ______________________________________________

Phone: ____________ Social Security #: ____________ DOB: ____________

Medicaid #: ____________Medicare #:__________Third Party Ins. #:__________

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**Person completing application:** ______________________________

Relationship to applicant: ____________________Phone: ____________

**Please forward results to:** ______________________________

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**Service Coordinator:** ____________________ Agency: ____________

Address: ______________________________________________

Phone: ____________________ Email: ____________________

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**Contact for scheduling:** ☐ Applicant ☐ Service Coordinator

☐ Other: ________________________ Phone: ____________

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**Type of Residence**:

☐ Alone ☐ Parents or member of his/her family ☐ OMRDD/Agency Residence
☐ Homeless/Shelter ☐ Family Care Provider ☐ Friends/Housemates
☐ DSS/Foster Care ☐ Other ______________

Name of Residential Contact: ______________________________

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**Does applicant have a legal guardian?** *Yes ☐ No ☐

Name of legal guardian: ____________________ Phone: ____________

Address: ______________________________ Email: ____________

*Guardian must be notified and must give consent for the service being requested.
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Medical Information:

Primary Care Physician: ______________________________ Phone: ______________________________

Address: ____

Psychiatrist's Name: _______________________________ Phone: _________________________________

Is the individual currently receiving any other Article 16 Clinic Services? (to avoid duplication of service): No ☐ *Yes ☐ Check all that apply and list agency name/phone #

☐ Psychology ____________________________ ☐ Rehabilitation Counseling ____________________

☐ Psychiatry _____________________________ ☐ Nutrition Counseling ________________________

☐ Social Work ____________________________ ☐ OT/ PT ____________________________________

Services Requested: ***(See attached <u>Required Documentation Guideline</u>)***

<u>One-time</u>

☐ Psychological Assessment **(IQ)**
☐ Psychological Assessment **(Adaptive)**
☐ Sexuality Assessment
☐ Guardianship/Medical Affidavits

<u>On-going</u>

☐ Social/Emotional/Behavioral Counseling
☐ Physical Therapy*
☐ Occupational Therapy*

* Prescription for Assessment from Primary Care Physician ***(PT/OT only)***

Site Attending:

☐ East Syracuse Day Habilitation
☐ North Midler Day Habilitation
☐ Onondaga Day Habilitation
☐ Monarch __________________
☐ Galeville Day Habilitation
☐ Lakeshore Day Habilitation
☐ Fremont Day Habilitation
☐ Salina Day Habilitation
☐ Hampton Day Habilitation

Briefly describe the individual's need for service and issues or concerns:

FOR OFFICE USE ONLY

I have reviewed all of the medical documents requested and forwarded to the clinic related to the care of this individual and give my approval for the service(s) requested.

____,MD Date: ________________________________
Medical Director

____ Date: ________________________________
Clinic Treatment Coordinator

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# *Horizons Article 16 Clinic Services*

### *One-time Services*

Psychological Assessment **(IQ)**
Psychological Assessment **(Adaptive)**
Sexuality Assessment
Guardianship/Medical Affidavits

### *On-going Services*

Social Work Counseling
Rehabilitation/Vocational Counseling
Physical Therapy
Occupational Therapy

# *Required Documentation*

***One-time* services require**:

- A Copy of Current Insurance Cards
- Prior Psychological Testing
- Individualized Service Plan (ISP) or Individualized Education Plan (IEP) (except Affidavits)

***On-going* services require**:

- A Copy of Current Insurance Cards
- Prior Psychological Testing
- Individualized Service Plan (ISP) or Individualized Education Plan (IEP) (except Affidavits)
- Current Physical Exam and Medication Regimen (if any) on Physician's Letterhead
- Two consecutive years of Negative PPD Readings (*One from within the last 12 months)
- Notice of Decision (Eligibility Determination)

\* *Can be administered in our Clinic. Use PPD (Mantoux) Referral Form available at www.arcon.org or call our Clinic to request.*
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