



Mail, scan, or fax completed application with required documentation to:
Arc of Onondaga - Horizons Article 16 Clinic
 600 South Wilbur Avenue, Syracuse, NY 13204
 Scan application to: blyon@arcon.org
 Fax application to: 315-476-1582

~~~~~

For more information, call the Treatment Coordinator, Barry Lyon, at  
 315-476-7441 x1111

**Horizons Article 16 Clinic Application**

**Applicant's Name:** \_\_\_\_\_ **TABS ID:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Social Security #:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**FOR OFFICE USE ONLY**

**Service:** \_\_\_\_\_ **Assigned Clinician:** \_\_\_\_\_ **Site:** \_\_\_\_\_

**Clinic Admission Date:** \_\_\_\_\_ **Evaluation 1:** \_\_\_\_\_ **Evaluation 2:** \_\_\_\_\_

**Date of Psychological:** \_\_\_\_\_ **ICD-10:** \_\_\_\_\_ **Date of ISP:** \_\_\_\_\_

**Date of PPD:** \_\_\_\_\_ **Date of PPD 2:** \_\_\_\_\_ **Rx:** \_\_\_\_\_

**Insurance: Medicaid:**  **Card Received:**  **Managed Care:**  **Card Received:**   
**Medicare:**  **Card Received:**  **Third Party:**  **Card Received:**

**Notes:** \_\_\_\_\_

**Insurance Information: (INCLUDE COPIES OF ALL INSURANCE CARDS WITH THE APPLICATION)**

**Medicaid #:** \_\_\_\_\_ **Medicare #:** \_\_\_\_\_

**Third Party Insurance Information (if applicable):**

**Insurance Name:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Group # (Plan, Local, Policy #):** \_\_\_\_\_ **Insured's Id#:** \_\_\_\_\_

**Policy Holder's Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Contact in case of insurance questions: Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Contact Information:**

Person completing application: \_\_\_\_\_

Relationship to applicant: \_\_\_\_\_ Phone: \_\_\_\_\_

Please forward results to: \_\_\_\_\_

**Care Manager:** \_\_\_\_\_ Agency: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**Central Plan Coordinator:** \_\_\_\_\_ Agency: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**Contact for scheduling:**  Applicant  Service Coordinator

Other: \_\_\_\_\_ Phone: \_\_\_\_\_

**Type of Residence:**

- Alone
- Homeless/Shelter
- DSS/Foster Care
- Parents or member of his/her family
- Family Care Provider
- Other \_\_\_\_\_
- OPWDD/Agency Residence
- Friends/Housemates

Name /Agency of Residential Contact: \_\_\_\_\_

**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.

**Medical Information:**

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Psychiatrist's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**Is the individual currently receiving OT, PT or Counseling Services elsewhere?** (to avoid duplication of service): No  \*Yes  If Yes, Where? \_\_\_\_\_

**Site Attending:**

- East Syracuse Day Habilitation
- North Midler Day Habilitation
- Lancaster Day Habilitation
- Hartwick
- Monarch \_\_\_\_\_
- Galeville Day Habilitation
- Fremont Day Habilitation
- Jefferson
- Salina Day Habilitation
- Oneonta
- Hampton Day Habilitation

Services Requested: (See following page for Required Documentation)

**One-time**

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

**On-going**

- Social/Emotional/Behavioral Counseling
- Physical Therapy\*
- Occupational Therapy\*
- Speech Therapy (JRC and Oneonta only)\*

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

**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  
Medical Director

\_\_\_\_\_  
Date

\_\_\_\_\_  
Clinic Treatment Coordinator

\_\_\_\_\_  
Date

**Horizons Article 16 Clinic Services Documentation Requirements**

**One-time Services**

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

**On-going Services**

- Social Work Counseling
- Physical Therapy
- Occupational Therapy
- Speech Therapy

**Required Documentation for one-time services:**

- A Copy of Current Insurance Cards
- Prior Psychological Testing
- \* Prescription for Assessment from Primary Care Physician (*PT/OT only*)

**Required Documentaion for on-going services:**

- A Copy of Current Insurance Cards
- Prior Psychological Testing
- Eligibility Determination letter
- Care Plan
- One Negative PPD Reading from within the last 12 months.
- Primary Care Physician's Prescription for OT and PT services