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
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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: _____

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**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:** _____

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**Insurance Information:** ***INCLUDE COPIES OF ALL INSURANCE CARDS (FRONT AND BACK)***

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: _____

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

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 ☐Monarch _____ ☐Salina Day Habilitation
☐North Midler Day Habilitation ☐Galeville Day Habilitation ☐Oneonta
☐Lancaster Day Habilitation ☐Fremont Day Habilitation ☐Hampton Day Habilitation
☐Hartwick ☐Jefferson

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

* 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
- A 2-step PPD (skin test) or an IGRA blood test (Quantiferon Gold or T-SPOT)
-For OT and PT-Primary Care Physician's Prescription and most current Physical Exam