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: _____

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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: _____

---

**Contact Information:**

Person completing application: _____

Relationship to applicant: _____Phone: _____

Please forward results to**:** _____

**Care Manager:** _____ Agency: _____

Address: _____

Phone: _____ Email: _____

**Central Plan Coordinator:** _____ Agency: _____

Phone: _____ Email: _____
~~~~

Contact for scheduling: ☐ Applicant ☐ Care Manager

☐ Other: _____ Phone: _____

Email address: _____

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: _____

Phone: _____ Email: _____

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 <u>Required Documentation</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*
☐Speech Therapy

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

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

Page 2 of 3

Horizons Article 16 Clinic Services Documentation Requirements

One-time Services	***On-going Services***
Psychological Assessment **(IQ)**	Social Work Counseling
Psychological Assessment **(Adaptive)**	Physical Therapy
Sexuality Assessment	Occupational Therapy
Guardianship/Medical Affidavits	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 -Life Plan
-For OT and PT-Primary Care Physician's Prescription and most current Physical Exam