



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

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

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

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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: \_\_\_\_\_

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

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**Day Habilitation Site Attending:**

- East Syracuse Day Habilitation  Otsego  Fremont Day Habilitation  
 North Midler Day Habilitation  Jefferson/St. Lawrence  Oneonta  
 Lancaster Day Habilitation  Galeville Day Habilitation  Hampton Day Habilitation

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**Services Requested:** (See following page for Required Documentation)

**One-time**

- Psychological Assessment (**IQ**)  
 Psychological Assessment (**Adaptive**)  
 Sexuality Assessment  
 Guardianship Evaluation/Affidavit  
Autism Assessment  
Capacity-Medical/Dental Procedure

**On-going**

- Social/Emotional/Behavioral Counseling  
 Physical Therapy\*  
 Occupational Therapy\*  
 Speech Therapy

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

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

## **Horizons Article 16 Clinic Services Documentation Requirements**

### **Documentation Needed For Social Work Referral:**

1. Prescription from Medical Provider requesting a “Social Work Evaluation”
2. Most current Psychological Testing
3. Most current IEP/Life Plan
4. Copies of Insurance Cards

### **Documentation Needed For OT/PT/SLP Referral:**

1. Prescription from Medical Provider requesting a discipline specific evaluation
2. Most current Physical Exam
3. Most current Psychological Testing
4. Most current IEP/Life Plan
5. Copies of Insurance Cards

### **Documentation Needed For IQ testing, Adaptive Assessments, and Autism Assessments:**

1. Most current Psychological Testing
2. Most current IEP/Life Plan
3. Copies of Insurance Cards
4. Letter from Eligibility Clinic (if there has been correspondence)
5. Medical Documentation (if pertinent to OPWDD eligibility requirements)

### **Documentation Needed for Capacity Assessments (Guardianship, Medical Procedure, etc.):**

1. Most current Psychological Testing
2. Most current IEP/Life Plan
3. Copies of Insurance Cards

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