



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: 315-370-3089
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For more information, call the Treatment Coordinator, Barry Lyon, at 315-401-0671

**Horizons Article 16 Clinic Application**

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

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

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

**Race (optional):** \_\_\_\_\_

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

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

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

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

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

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

**Contact for scheduling:**  Applicant  Care Manager Relationship to applicant: \_\_\_\_\_

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: \_\_\_\_\_

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/Oneonta  Fremont Day Habilitation  
 Wilbur Day Habilitation  Jefferson  St. Lawrence-Norwood  
 Lancaster Day Habilitation  Galeville Day Habilitation  St. Lawrence-Canton  
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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**Please describe in specific detail the individual's need for service and issues or concerns:**

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**How did you hear about us?**

Social Media

Outreach Fair

Care Manager

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

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

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

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

1. Prescription from Medical Provider requesting 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

Please note, all services provided at an Article 16 Clinic are billed to Medicaid. If an individual does not have Medicaid, you may self pay and submit to insurance for applicable reimbursement based on type of plan. Any changes to insurance, including the addition of any third party insurance, must be submitted to Horizons Clinic prior to scheduling.