Request for Therapeutic Services Interest Form

Background Information

Name: _____ Today's Date: _____

Date of Birth: _____ Gender: _____

Address: _____ City/Zip: _____

Current Living Situation:

- ❑ Group home
- ❑ Own Family
- ❑ Independent Home
- ❑ Shared home
- ❑ Other: _____

Medicaid #: _____ State ID #: _____

Conservator: (Does the individual have a conservator/guardian? If so, who is that individual?)

- Name: _____
- Phone: _____
- Email: _____

Consent for Referral: As the applicant or conservator/guardian for the applicant, I give consent to the admission and care offered within the requested program.

Signature: _____

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Program Interest

Please circle each program being requested

Social Skills Groups	Recreational Therapy	Sensory Integration	Physical Therapy

What is your environmental preference?

- ❑ In-clinic
- ❑ In-home
- ❑ Virtual (if possible)
- ❑ No preference

Contacts	Name	Phone	Email
Parent/Guardian/ Conservator			
Primary Care Physician			
Psychiatrist			
Neurologist			
Other Physician Specialty: _____			
Other Physician Specialty: _____			
Other Physician Specialty: _____			

Reason for Request: Please explain why the individual is requesting therapeutic services. What are they hoping to gain?		
Prior Therapy or services: Is the individual currently receiving therapy, or have they had this type of service in the past? If so, when and by who?		
Physical Health Diagnoses: List any medical diagnoses or physical health problems (visual impairment, arthritis, paralysis, etc.)		
Current home situation Housemates? Level of Independence? Individuals within his/her circle that are important to him/her?		
Day Activities Describe the person's daily life routine.		
Medicaid Waiver Does the individual qualify for Medicaid Wavier services? If so, for which Medicaid waiver services has funding been applied or approved?	☐Statewide Waiver ☐Self-Determination Waiver ☐ Employment and Community First Choices ☐ Other_____	☐None ☐In Process of Approval ☐Approved
Insurance: Is the individual currently covered by any insurance? If so, what kind?	☐Does have insurance ☐Does not have insurance Coverage	If yes: Insurance type: _____ Group #: _____ Policy #: _____

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Behavior Information

Employment Does the individual have a job or want to pursue future employment?	
Communication Is the individual verbal? Can they independently request wants/needs using language?	
Alternative Communication Does the individual use a specific type of assistive technology to communicate? If so, what do they use?	
Self-Care Describe self-care abilities. (Showering, toileting, dressing, laundry, etc.)	
Chores Describe household maintenance abilities. (dishes, vacuuming, cleaning bathroom, etc.)	
Eating Explain eating habits of the individual (picky eater, difficulty swallowing, over-eating, eating with utensils, eating non-food items, etc.)	
Fears/Concerns Is the individual afraid of anything? Do they not want to be around certain people or things?	
Safety Are there concerns about the individual's safety awareness?	
Transportation Does the individual drive, use public transportation, etc.?	
Routines Does the individual engage in any routine/ritualistic behaviors? If so, please describe	

Recreation/Leisure What does the individual like to do for fun? What are their hobbies and interests? What activities do they enjoy?	
Social Skills Please describe the individual's social life. Do they have friends? Do they enjoy being around others and engaging in group activities?	
Physical Barriers Can the individual walk, or do they require assistance navigating their daily life? Please explain	

Maladaptive Behaviors

Behavior	Please Describe: Intensity, Duration, etc.
Physical Aggression (hitting, spitting, kicking, biting, pushing etc.)	
Self-Injury (head-banging, picking, etc.)	
Property Destruction (punching walls, breaking items, etc.)	
Elopement (running away from home or family, etc.)	
Stimming behaviors (Repetitive or unusual movements like hand flapping)	
Sexually Inappropriate Behavior (inappropriate touching, etc.)	

Other Please list any other behaviors that are of concern	

Document attachments

Please provide the following documents for review with this application:

- Most recent annual Physical
- Current list of medical providers, with phone numbers and addresses
- Historical clinical assessments (medical, psychiatric, behavior, therapies)
- ISP/IEP (Most recent IEP if out of school)
- Behavior Support Plan, Most Recent CSMR or Follow Up Note.
- Proof of insurance- photocopy of front/back of insurance card
- Proof of Identity- photocopy of ID/license.
- Proof of Diagnosis, if applicable
- Referral from doctor/provider for therapy being requested, if applicable