Children's Therapy Clinic

The Place of Little Miracles

Date: _____

Dear Parent/Guardian:

Your child was referred to us by:

☐ Yourself

☐ The following clinic or physician: _____

☐ WV Birth to Three Practitioner: _____

The referral is for:

☐ Physical Therapy

☐ Occupational Therapy

☐ Speech Therapy

☐ Social Skills Group

☐ Music Therapy

Please fill out the enclosed application and return within two weeks (14 days.) If you have any questions, please contact me at (304) 342-9515.

Sincerely,

Valicia Leary

Valicia Leary
Executive Director

Children's Therapy Clinic · 113 Lakeview Drive Charleston, WV 25313
www.childrenstherapyclinic.com · Phone 342-9515 · Fax 342-9414

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Dear Parent/Guardian:

Thank you for choosing Children's Therapy Clinic, Inc. (CTC) for your child's care. Enclosed you will find several forms for you to complete. The purpose of these forms is to determine your child's eligibility for our program, and to obtain your child's records from other doctors, hospitals, etc., **before** your child's appointment. Applications **MUST** be returned before a child is determined eligible for services and placed on the waiting list. To help you complete the forms, we've included instructions below. If you have any questions, please call Valicia Leary at (304) 342-9515.

A. Intake Form

Please fill in the blanks on both pages of the form. Contact your child's physician to obtain a written order for treatment before your child's first visit to the Clinic. This information must be received before a visit will be scheduled for your child.

B. Insurance Verification Form

Please complete **all** sections of this form. If it is possible for you to do so, please send a copy of your child's insurance card (front and back). If your child does not have insurance, please indicate this on the form. Sign and date the form.

C. Statement of Understanding – Form A and Application for Admission to Program – Form B

The mission of CTC is to provide therapeutic services to children, ages birth to eighteen, who are either (1) from economically disadvantaged families, or (2) from families with insufficient or no insurance coverage for their condition. CTC charges fees for services using a sliding scale based on Federal Poverty Level guidelines. Therefore, applicants are required to provide income information so that the correct fees can be charged. Please complete all lines of the Statement of Understanding – Form A and the Application for Admission to the Program – Form B.

If your child qualifies for admission to the program based on insufficient insurance coverage, **you will be required to provide the following information**: (1) a denial letter from the insurance company, or (2) direct confirmation of such through the insurance verification process. For the purposes of this policy, insufficient insurance coverage is defined as follows: The number of therapy sessions ordered by the physician exceeds the number of therapy sessions covered by the insurance company.

Please read the forms carefully, fill in the blanks, then sign and date the form.

D. Health Information Record and Doctor's Order for Therapy

Please have your child's physician complete the Health Information Record and write an order for the therapy type(s) you are applying for. PLEASE NOTE: we do not need an order from the doctor for Social Skills Groups or Music Therapy.

Thank you for your assistance.

Valicia Leary

Valicia Leary
Executive Director

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INTAKE FORM

Child's Name _____ **Date of Birth** _____ **Age** ____ **Today's Date** _____

Child's Ethnicity: (This information is used *only* for grants requiring statistical reports and is reported anonymously.)

☐White /Caucasian ☐Asian
☐Black/African-American ☐Multi-Racial / Multi-Ethnic
☐Hispanic ☐Other

Parent or Guardian 1

Name:_____

Address: _____

City:_____ State_____ Zip_____

County:_____

Phone Numbers

(home) _____

(work) _____

(cell / alternative)_____

email address: _____

Parent or Guardian 2

Name:_____

Address (if different from above): _____

City:_____ State_____ Zip_____

County:_____

Phone Numbers

(home) _____

(work) _____

(cell / alternative)_____

email address: _____

If parents are separated or divorced, are there special custody arrangements? _____

If so, what are they?_____

* **Appointment Reminder**: Children's Therapy Clinic may attempt to call you to confirm an appointment.

May we call to remind you of appointments? Yes ☐ No ☐ May we leave a message? Yes ☐ No ☐

Preferred method of communication: ☐Call ☐Text ☐Email

Child's Physician_____ Telephone _____

PLEASE HAVE PHYSICIAN SEND AN ORDER FOR EVALUATION AND TREATMENT BY FAX: (304) 342-9414 or MAIL: Children's Therapy Clinic, 113 Lakeview Drive, Charleston, WV 25313.

Reason for Referral (Diagnosis) _____

Is your child involved with other agencies? _____

☐Birth to Three ☐School Services ☐Other agencies: Please list _____

Previous Therapy Received _____

Does your child receive benefits from Title 19 Waiver? No ☐ Yes ☐ Agency: _____

School _____ Grade _____

Needs: (check all that apply)

☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy

☐ Social Skills Group ☐ Music Therapy

Referral Screening Questions

1. Has your child had any major medical problems? _____

_____

2. Are there concerns about your child's hearing and/or vision? _____

3. Are there concerns with child's feeding? _____

4. Do you feel that your child is doing the same things as other children his or her age (e.g., crawling, walking, etc.)?

_____

_____

5. Does your child use any assistive devices (e.g., wheelchair, braces, walker, splints, communication etc.)?

_____

6. What types of toys does your child prefer? How does he/she play with them?

_____

_____

7. How does your child communicate? _____

_____

8. What outcome would you like from therapy? _____

_____

9. What are your child's strengths? _____

_____

10. Are there other concerns you would like to share? _____

_____

_____

Signature of Parent/Guardian_____ **Date** _____

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INSURANCE VERIFICATION FORM

- Please send a copy of your child's insurance card with application.

Child's Name:
ID#:

Subscriber Name:
Subscriber ID#:
Group #:

Insurance Company:
Address: Telephone Number:

Effective date of policy:
Family Coverage? _____ Yes _____ No
Date Terminated:

Deductible amount:
Amount of deductible met:

Therapy Services Covered:

Type of Service	Service Limits
Physical Therapy	
Occupational Therapy	
Speech Therapy	
Specialty Services	
Other	

Signature of Parent/Guardian: _____

Date: _____

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STATEMENT OF UNDERSTANDING – FORM A

The information I have given concerning the size of my family and my family's gross annual income from all sources is true, accurate and complete to the best of my knowledge. I have given this information concerning my financial situation and my means and ability to pay for the purpose of procuring therapeutic services for _____. I understand that Children's Therapy Clinic, Inc. will rely on such information to determine _____'s eligibility to the program.

I understand that knowingly giving false information in this case may result in criminal prosecution under the laws of the State of West Virginia.

I agree to report any change in either my income or my family size to Children's Therapy Clinic, Inc. (CTC) before or at the time of my next contact with the Clinic. I know that the information I have given will be relied upon until it is changed.

I understand that _____'s eligibility status will be reviewed on an annual basis and adjusted according to my family income and size at the time of review. If CTC has reason to suspect that the information I have given is untrue, incomplete, or inaccurate or that I have not properly reported changes, CTC may initiate a review of _____'s eligibility and I will authorize access to all my financial records. If I refuse such review or authorization, CTC will no longer provide services to my child/ward.

Parent/Legal Guardian Signature: _____

Date: _____

****FOR OFFICE USE ONLY** DETERMINATION OF ELIGIBILITY**

After careful examination of the applicant's family size, family situation, and financial situation, it is my decision that this application for services be: ☐ Granted ☐ Denied

This determination shall remain in effect for one year from this date, at which time the applicant's financial situation will be reviewed to re-evaluate eligibility.

Authorized by: _____ Date: _____

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APPLICATION FOR ADMISSION TO PROGRAM (FORM B)

Please note that the information requested on this form will be used to determine eligibility for services at Children's Therapy Clinic. It will be reviewed by the Executive Director.

Head of Household _____ Relationship to Client _____

Please list all members of household (including client)

_____ _____

_____ _____

_____ _____

_____ _____

Head of Household's Employer: Spouse's Employer:

_____ _____

Employer's Phone Number: _____ Employer's Phone Number: _____

Employer's Address: _____ Employer's Address: _____

_____ _____

Family Income Determination

Income Sources:

	Amount		Amount
Yearly Wages- Head	$_____	Pensions/Annuities	$_____
Yearly Wages- Spouse	$_____	WV Works (TANF)	$_____
Self-Employment Income	$_____	SNAP	$_____
Seasonal Employment	$_____	Child Support/Alimony	$_____
Disability	$_____	Veteran's Benefits	$_____
Unemployment Benefits	$_____	Other (Specify)	$_____

Total Annual Income: $_____

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HEALTH INFORMATION RECORD (MUST be completed by child's physician)

Child's Name: _____ Date of Birth: _____

Address: _____ Phone: _____

City: _____ Parents: _____

State: _____ Zip: _____ _____

ALLERGIES:

Medications: _____ Reaction: _____

Foods: _____ Reaction: _____

MEDICATIONS & RESTRICTIONS:

Current Medications: _____

Dietary Concerns: _____

Activity Restrictions: _____

SIGNIFICANT HEALTH ISSUES (circle all that apply): Seizures Asthma Diabetes Other: _____

EMERGENCY CONTACT INFO:

Name : _____ Relation: _____

Phone: _____

Physician: _____

Physician's Phone: _____

IMMUNIZATION RECORD:

Please attach a copy of child's Immunization Record from Physician

Immunizations up to date? ☐ yes ☐ no (catch-up schedule: _____)

Physician Name: _____ Signature: _____ Date: _____

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SLIDING SCALE FEES

Family income below 200% of the Federal Poverty Level (FPL) = **no fee**

Family income between 200% and 250% of FPL = **$5** per therapy session

Family income between 251% and 300% of FPL = **$10** per therapy session

Family income between 301% and 500% of FPL = **$25** per therapy session

Family income above 500% of FPL = **$50** per therapy session

Waiver of any of the above fees will be considered on an individual case basis by the Finance Committee.

***Music Therapy Fees:**

Family income below 200% of the Federal Poverty Level (FPL) = $20/session

Family income above 200% of the Federal Poverty Level (FPL) = $40/session