CENTER FOR HEALTH SERVICES
THERAPY. TREATMENT. CARE

Application Form

Date: ______________ Form completed by :___________________

PATIENT INFORMATION

Last Name: _________________________________ Age: ________________

First Name:_________________________________ D,O.B.:________________

Middle Name:_______________________________ Gender:_________________

Adress: ____

City:_________________________ State :___________________ Zip: _______________

Primary Diagnosis:__________________________ Date of Diagnosis:_____________

Other Condition:____________________________ Date of Diagnosis:_____________

Other Condition:____________________________ Date of Diagnosis:_____________

Parent's Marital Status: Married Separated Divorced Single Widowed

Child Lives With : Both Parents Mother Father Other _______________________

MOTHER OR LEGAL GUARDIAN INFORMATION

Full Name: ____________________________ Relationship to child:_____________

Address: (only if different from applicant) Age:_____________

____________________________________ Occupation:_________________________
City:_______________________________ Name of Employer:___________________
State:______________Zip Code:_________ Business Phone:_____________________
Home Phone: (if not different from applicant) Cell Phone:_____________________
Email:____

FATHER OR LEGAL GUARDIAN INFORMATION

Full Name: ______________________________ Relationship to child:_____________

Address: (only if different from applicant) Age:_____________

______________________________________ Occupation:__________________________

City:_________________________________ Name of Employer:___________________

State:______________Zip Code:_________ Business Phone:_____________________

Home Phone: (if not different from applicant) Cell Phone:______________________

Email:____

APPLICANT'S SIBLINGS

Name:__________________________________ Age: ________ Gender:_____________

Name:__________________________________ Age: ________ Gender:_____________

Name:__________________________________ Age: ________ Gender:_____________

Name:__________________________________ Age: ________ Gender:_____________

INSURANCE INFORMATION

All information below MUST be completed in its entirely. Incomplete forms will be returned.

CLIENT INFORMATION

Name:____ DOB_________________________

PRIMARY POLICY HOLDER INFORMATION

Name: _______________________________________ DOB:________________________

Address:____

Phone Number:____

Relationship to Client:_____ Child _____Step child ___Grand child ___ other dependent

PRIMARY INSURANCE INFORMATION

Primary Insurance Carrier:________________________ Plan type: ________________

Policy Number: ________________________________ Group No:________________

Group Name/Employer:__________________ Authorisation# (if possible):__________

Case Manager Name and Contact # (if possible):________________________________

SECONDARY INSURANCE INFORMATION

Secondary Insurance Carrier:______________________ Plan type:_______________

Policy Number:_________________________________ Group No:_______________

Group Name/Employer:__________________ Authorisation# (if possible):__________

Case Manager Name and Contact # (if possible):________________________________

SIGNATURE ON FILE

I authorize CENTER FOR HEALTH SERVICES (CHS) to release and receive information from the above-identified insurance company. The purpose of releasing/exchanging information is limited to filing claims for services rendered.
I understand that I am responsible for my bill. I release this office from all liabilities incurred due to non -reimbursed referrals, I authorise CHS to act as my agent to obtain payment. I authorize payment directly to CFS. I permit a copy to this authorisation to be used in place of the original.

Parent/Guardian Signature:________________________
Date:_________________

Patient Information Form

PATIENT INFORMATION

Name:____ DOB:________________

STATEMENT OF PROBLEM

1. What is the presenting problem? (include symptoms and their impact on overall function)

____
____
____
____

2. Describe the onset of the problem. (identification of when the observed problem began and the progression of problem)

____
____
____
____

3. What, if any, behavior issues does your child have? (e.g.,self-injurious,aggressive towards others,etc) Please explain

____
____
____
____

MEDICAL INFORMATION

4.List past and current diagnosis.

____
____
____

____

5. Has your child ever been admitted to a hospital/treatment center for psychiatric, behavioral,or crisis situation?

________Yes No_______ if yes, please explain

____
____
____
____

6. Please summarize the hospital/treatment facilities observation, treatment(s), and effectiveness of treatment.

____
____
____
____

7. Is your child currently on medication? __________ Yes No___________

If yes please complete the chart below:

Name of current medication Current Dosage Administration Time(s) Used For

____
____
____
____
____

(Additional medication can be attached on a separate sheet of paper and stapled to this application)

8. Does your child receive any of the following? (If yes, please specify/explain below.)

Over- the- counter medication __________ Yes No_________

____

Home Remedies ____________ Yes No_____________

____

Herbal Therapy ___________Yes No_______________

____

Special Diet _______________ Yes No_____________

9. Are there any many medical conditions that need to be considered when delivering ABA treatment?

____________Yes _____________No If yes, please explain:

____

____

____

____

CHILDCARE AND EDUCATIONAL INFORMATION

10. What school does your child attend? ______________________________

Current grade level: _____________________

Address: ____

Phone: ____

11. How often does your child attend school? ________________ Days per week

____________________ hours per day

12. What are your child's strengths in school?_________________________________

13. What areas at school are most difficult for your child? ________________________

14. What type of class does your child participate in? ________ Self-contained

_________ Inclusion ___________ Regular

THERAPIES & SERVICES

15. What other services is your child currently receiving both in school and out of school? Please enclose a copy of the child's most recent IEP or IFSP and therapy goals from each area that is checked.

Services/ Therapy	Location Provider
___ Early Intervention Services	__ School Home __
___ Speech and/or language therapy	__ School Home __
___ Occupational and/or Physical therapy	__ School Home __
___ Vision services in school	__ School Home __
___ Hearing Services	__ School Home __
___ Other	__ School Home __
___ Other	__ School Home __

16. Please describe the results of these therapies in regards to success in achieving goals.

____
____
____
____
____

TREATMENT GOALS FOR PATIENTS

17. What are your immediate goals?

____

____

____

____

18. How do you see us in assisting you in meeting goals?

____

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____

____

19. What level of commitment are you willing to make at home in order for your child to achieve these goals?

____

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____

____

20. What, if anything else, would you like us to know about the patient? *(e.g., mode of communication, social skills, etc.)*

____

____

____

____

21. How did you learn about us?

____

____

____

Name of person completing this form *(please print)* ________________________________

Signature________________________________ Date ________________________

PREFERRED SCHEDULE REQUEST FORM

Patient Name:
____
Contact: ___________________________________ Cell Phone: ___________________
Email: ____

SELECT THE THERAPY SERVICES

ABA/Behaviour Therapy___
Speech Therapy___
Physical Therapy ____
Occupational Therapy___

Service: Home based Therapy Service _ Clinic based Therapy _

Services might be based on availability, we will continue to work with you.
Location: Home _ Clinic _

Weekly Frequency of Services for Therapist (1-3 hours sessions): __________________

Requested Days and Times (in order of preference) :
Day_________________________________ **Time**________________________________
____
____
____
____
____
____
____
____
____

Please note:

- We will try our best to accommodate your request, however scheduled sessions will depend on availability.
- Consultation services will be scheduled base on therapist hours have been established. Center for Health Services will work with you to provide you with the services you need.