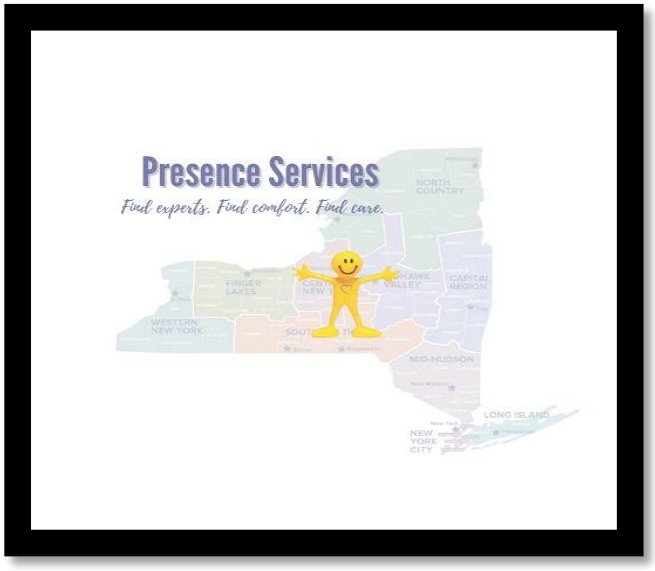
Presence Counseling and Developmental Services Request for Services



Documents needed for Admission:

- Life Plan (most recent existing on file)
- If Medicaid or Medicare, only provide the Medicaid number.
- If there is a dual advantage, Managed Care plan, BCBS, United Health Care, Anthem, Aetna, or Fidelis, etc., then we will need the front and back of the current card(s).
- Scripts are required for OT, PT, or SLP services from the individuals Primary Care provider.

Please fax or mail the requested services and documents needed for admission to Presence Counseling Services and Presence Developmental Services to:

Attn: Presence Intake

Address 115 Fall Street, Seneca Falls, NY 13148

Fax 315-515-5194

Email presenceintake@presencedevelopmental.com

website www.presencedevelopmental.com

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Name (last, first)	
DOB:	
Medicaid #	
Medicare ID# (optional)	
Other Ins. (Send a copy of the front and back of the card)	
Full address of Treatment Location. (Specify: Group Home, Private Home, Day Hab, Other)	
Treatment Location Contact's Name/Relationship	
Contact's best phone #	
Contact email	
If a Minor, guardian's name & date of birth	
Name, email, and phone of Care Manager. (Specify which CCO)	
Referred for: □ Occupational Therapy	Rehabilitation services aimed to support impaired fine motor skills, upper extremity strength, and cognitive impairments
Referred for: □ Physical Therapy	Rehabilitation services to increase endurance to gait, ambulation, stair climbing, and upper and lower body strength
Referred for: □ Speech Therapy	Rehabilitation targeted on the effects of expressive and receptive language disorders, swallowing disorders, and sign language to indicate needs and wants

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Referred for: □ Behavioral Psychotherapy/Counseling	1:1 Cognitive psychotherapy based on a Treatment Plan /Behavior Plan
Referred for: □ Counseling	Improving mental health, personal challenges and overall well-being.

CONSENT & FINANCIAL RELEASE STATEMENT

"I hereby consent to the *Direct Assignment of My Rights and Benefits,* and I authorize the release of any medical information necessary to my insurance providers and their agents to obtain payment to receive services from Presence Counseling Services and/ or Presence Developmental Services. I understand if my insurance plan sends payment for services, or other insurance documentation (such as Explanation of Benefits, Summary of Benefits, Monthly Summary) and lists Presence Counseling Services or Presence Developmental Services, it is my responsibility to forward this documentation and payment

I authorize the release of my medical information to the Group's Claims Administrators for the purpose of determining benefit eligibility and payment. This authorization will remain in effect until canceled by me in writing or until discharge."

☐ Check if the individual is unable to sign and the legal representative is completing the below on the individual's behalf.	
Name of Individual or Representative	
Title/Relationship to individual	
Signature	
Date of consent	

We look forward to supporting your request.