Children's Therapy Clinic
The Place of Little Miracles

Dear Parent/Guardian:

Thank you for choosing Children's Therapy Clinic, Inc. (CTC) for your child's care. Enclosed you will find several forms to be filled out. The purpose of these forms is to determine eligibility to the program and to obtain records on your child from other doctors, hospitals, etc., **before** your child's appointment. If you have questions after reviewing these documents, please call the director, Valicia Leary, at (304) 342-9515.

In order to process your child's paperwork more efficiently, a list of instructions is provided below.

A. Intake Form

Please fill in the blanks on both pages of the form.

Please contact your child's physician to obtain a written order for treatment (usually on a prescription form) 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. Please 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 twenty-three, who fall into one of the following categories: (1) Economically disadvantaged and/or (2) Children having insufficient or no insurance coverage for their condition.

Children's Therapy Clinic charges fees for services using a sliding scale based on the Federal Poverty Level guidelines. Applicants are required to provide income information. Please complete all lines of the Statement of Understanding – Form A and the Application for Admission to the Program – Form B and send a copy of your most recent Federal Tax Return with your application.

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 fill in the blanks reading the form carefully, then sign and date the form.

D. Health Information Record and Doctor Prescription

Please have your child's physician complete the Health Information Record and write a prescription for the therapy type(s) you are applying for.

Thank you for your assistance.

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: _____

* **Appointment Reminder**: Children's Therapy Clinic may attempt to call you to confirm an appointment. Due to the confidential nature of your visits, we need your permission to call.

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

Child's Physician_____ Telephone _____

PLEASE HAVE PHYSICIAN SEND AN ORDER OR PRESCRIPTION FOR EVALUATION AND TREATMENT TO: Children's Therapy Clinic 113 Lakeview Drive, Charleston, WV 25313

Reason for Referral (Diagnosis) _____

Is your child involved with other agencies? _____ Please list _____

_____

Primary Insurance _____ Secondary Insurance _____

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

Previous Therapy Received _____

Applying based on: (check one)

☐ Income ☐ No Insurance ☐ Insufficient insurance coverage for condition (please attach denial letter.)

Needs: (check all that apply)

☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy

☐ Autism Socialization Group ☐ Music Therapy

School _____Grade _____
School Address _____

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

4. Does your child use any assistive devises (e.g., wheelchair, braces, walker, splints, etc.)?
_____
_____

Do you have any concerns about these?_____

5. How does your child participate in feeding? _____
_____

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

7. How does your child communicate? _____
_____

8. What does your child do when he/she is frustrated or angry? _____
_____

Signature of Parent/Guardian_____ Date _____

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INSURANCE VERIFICATION FORM

Prepared by: _____

Date: _____

- 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 _____ Date of Birth _____

Please list all members of household (including client)

_____ _____

_____ _____

_____ _____

_____ _____

Head of Household's Employer:

_____

Spouse's Employer:

_____

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

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

Family Income Determination

Income Sources:	**Amount**		
Yearly Wages- Head	$_____	Social Security	$_____
Yearly Wages- Spouse	$_____	Pensions/Annuities	$_____
Personal Business Profits	$_____	Welfare	$_____
Seasonal Employment	$_____	Aid to Dep. Children	$_____
Disability/Insurance	$_____	Alimony	$_____
Unemployment Payments	$_____	Child Support	$_____
Veteran's Benefits	$_____	Food Stamps	$_____
		Other (Specify)	$_____

Total Annual Income: $_____

* copy of latest Federal Tax Return must accompany this form

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

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

Immunization	Enter Dates of Immunization
Dtap	☐ _____ ☐ _____ ☐ _____ ☐ _____ ☐ _____
Polio	☐ _____ ☐ _____ ☐ _____ ☐ _____
MMR	☐ _____ ☐ _____
Hib	☐ _____ ☐ _____ ☐ _____ ☐ _____
HepB	☐ _____ ☐ _____ ☐ _____
Varivax	☐ _____ ☐ _____

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

Physician Name: _____ Signature: _____ Date: _____

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.