Therapy & Learning Center
A service of Ayer's Children's Medical Center

DAY SERVICES PROGRAM APPLICATION

Name:_____ Date:_____

Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Alt. Phone:_____

Date of Birth:_____ Social Security Number:_____

Does the participant live: _____At home with parents/caregiver
_____In a Supported Living/Assisted Living home

Primary Diagnosis:_____

Services Requested: (mark all that apply)

___ Community Based Services
___ Work/Supported Employment Services
___ Community Memberships (ie: YMCA, LIFT)
___ On Site Services
___ Volunteer Opportunities
___ Other (please explain below)

_____
_____
_____

Descriptive Information

Height:_____ Weight:_____ Sex: M F

Is this individual legally competent? Yes No

Parent / Conservator Information

Name(s):_____

Address: (indicate if same as above)_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____

Cell Phone:_____ Cell Phone Carrier:_____

Email Address:_____

First Emergency Contact

Name:_____

Relationship to participant:_____ Phone:_____

Second Emergency Contact

Name:_____

Relationship to participant:_____ Phone:_____

Activities

Attends Church	Yes____ No____
Shops with Supervision	Yes____ No____
Shops without Supervision	Yes____ No____
Manages Sums of Money	Yes____ No____
Amount Applicant Can Manage $ _____	
Walks Independently in own Yard	Yes____ No____
Walks Independently in Neighborhood	Yes____ No____
Walks Independently More than One Mile	Yes____ No____
Goes Out to Eat Alone	Yes____ No____
Goes Out to Eat with Family	Yes____ No____
Goes Out to Eat with Friends	Yes____ No____
Goes to the Movies	Yes____ No____
Watch TV	Yes____ No____
Can use DVD/VCR	Yes____ No____
Plays Games Independently	Yes____ No____
Plays Games w/ Others	Yes____ No____
Reads	Yes____ No____
Writes	Yes____ No____
Operates the Radio	Yes____ No____
Enjoys Crafts	Yes____ No____
Other:_____	

What chores does applicant perform at home?_____

Any additional comments or information regarding this applicant?_____

Medical History

1. ____Measles: Mild____ Moderate____ Severe____
2. ____Mumps: Mild____ Moderate____ Severe____
3. ____Whooping Cough: Mild____ Moderate____ Severe____
4. ____Chicken Pox: Mild____ Moderate____ Severe____
5. ____Encephalitis: Mild____ Moderate____ Severe____
6. ____Meningitis: Mild____ Moderate____ Severe____

Where were immunizations received?_____

Has applicant ever had a seizure? Yes____ No____ **If Yes, please indicate at what age seizures began.**_____

Does applicant continue to have seizures? Yes____ No____ **If Yes, how frequent have these been?**_____

Does the applicant require mobility equipment/specialized appliances? (Ex: wheelchair)

Yes____ No____ **If Yes, please list type and purpose.**_____

Please indicate any drug allergies:_____

Other allergies:_____

Does the applicant have a history of alcohol and/or drug abuse? Yes____ No____

If Yes, please describe treatment received._____

Physician Information

Name:_____ Phone:_____

Clinic / Hospital:_____

Address:_____ City:_____ State:_____ Zip:_____

Medical Information

MR Level: *circle which applies* Mild Moderate Severe

Competency Status: *circle which applies* Competent Incompetent

Other Disabilities / Diagnoses:_____

Allergies: (food, drug, etc.)_____

Medication History of Applicant (Include both prescription and any over the counter medication) ***use the back of this page if more room is needed***

Drug	Dose	Doctor	Reason	Date Started

Other Specialists

Name:_____ Phone:_____

Clinic / Hospital:_____

Address:_____ City:_____ State:_____ Zip:_____

DIDD Support Coordinator/CHOICES Care Coordinator (if applicable)

Name:_____

Agency:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone Numbers:_____

Therapists (if applicable)

Name:_____

Agency:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone Numbers:_____

Other Services Received (if applicable)

Name:_____

Agency:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone Numbers:_____

Insurance Information

Primary Insurance:_____ Phone:_____

Subscriber/ID#:_____ Group/Policy#:_____

Name of Card Holder:_____

Card Holder DOB:_____ Effective Date:_____

Secondary Insurance: _____ Phone:_____

Subscriber/ID#:_____ Group/Policy#:_____

Name of Card Holder:_____

Card Holder DOB:_____ Effective Date:_____

Medicaid Number:_____

Financial Information

Who is Representative Payee?_____

Patient Consent for Treatment and Financial Responsibility:

1. I consent for the above individual to receive therapy services by the T&LC.
2. I consent to the release of all medical records to the referring and family physicians and to my insurance company, if applicable. I allow fax transmittal of medical records if necessary.
3. I agree that I will promptly notify T&LC of any changes in the above information.

4. I authorize the insurance companies listed above; TennCare, Medicaid and/or Medicare, if applicable, to make payments directly to T&LC for any covered services provided.
5. I agree to be financially responsible for payment. Although insurance may be assigned to and directly payable to T&LC, I understand that any part of the account not paid by insurance is owing and payable.
6. I understand that I am financially responsible for any deductible, co-pay or services not covered by insurance.
7. Required services, billable through the Department of Mental Retardation Services, that are specified on an Individual Support Plan are provided at no to the families.
8. I consent to the release of any medical information necessary to process medical claims and request payment of medical benefits to T&LC for services rendered.
9. I understand that accounts past due may be turned over to a collections agency.
10. I have read and fully understand the above consent for treatment and financial responsibility.

_____ _____

Parent/Conservator/Caregiver Signature Date