Mail, scan, or fax completed application with required documentation to:

Suburban Adult Services, Inc. - Article 16 Clinic
960 West Maple Court, Elma, NY 14059
Scan application to: wsherwood@sasinc.org
Fax application to: 716-560-1444

For more information, call the Intake Coordinator Wendy Sherwood at 716-805-1555 Ext 226

SASi Article 16 Clinic Referral

Applicant's Name: _____ TABS ID: _____

Address: _____

Phone: _____ Social Security #: _____ DOB: _____

Insurance Information: (*INCLUDE COPIES OF ALL INSURANCE CARDS WITH THE APPLICATION)*

Medicaid #: _____ Medicare #: _____

Third Party Insurance Information (if applicable):

Insurance Name: _____ Phone #: _____

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

Group # (Plan, Local, Policy #): _____ Insured's Id#: _____

Policy Holder's Name: _____ DOB: _____

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

Contact in case of insurance questions: Name: _____ Phone: _____

Contact Information:

Person completing application: _____

Relationship to applicant: _____ Phone: _____

Please forward results to: _____

Care Coordinator: _____ Agency: _____

Address: _____

Phone: _____ Email: _____

Contact for scheduling: ☐ Applicant ☑ Care Coordinator

☐ Other: _____ Phone: _____

Type of Residence:

☐ Alone
☑ Homeless/Shelter
☑ DSS/Foster Care
☑ Parents or member of his/her family
☑ Family Care Provider
☑ Other _____
☑ OPWDD/Agency Residence
☑ Friends/Housemates

Name /Agency of Residential Contact: _____

Does applicant have a legal guardian? *Yes ☑ No ☑

Name of legal guardian: _____ Phone: _____

Address: _____ Email: _____

*Guardian must be notified and must give consent for the service being requested.

Medical Information:

Primary Care Physician: _____ Phone: _____

Address: _____

Psychiatrist's Name: _____ Phone: _____

Is the individual currently receiving OT, PT, Counseling Services, Speech Therapy or In-Home Care elsewhere? (to avoid duplication of service):

No ☐ *Yes ☐ If Yes, Where? _____

Services Requested: ***(See following page for Required Documentation)***

One-time

- ☐ Psychological Assessment **(IQ)**
- ☐ Psychological Assessment **(Adaptive)**
- ☐ Autism Assessment
- ☐ Sexuality Assessment
- ☐ Guardianship/Medical Affidavits
- ☐ Risk Assessment
- ☐ Consent Determination

On-going

- ☐ Social/Emotional/Behavioral Counseling
- ☐ Physical Therapy*
- ☐ Occupational Therapy*
- ☐ Speech Therapy
- ☐ Psychiatry
- ☐ Vocational Rehabilitation Counseling

* Prescription for Assessment from Primary Care Physician ***(PT/OT and Dysphagia Assessment only)***

Briefly describe the individual's need for service and issues or concerns:

SASi Article 16 Clinic Services Documentation Requirements

One-time Services

Psychological Assessment (IQ)
Psychological Assessment(Adaptive)
Autism Assessment
Sexuality Assessment
Guardianship/Medical Affidavits
Risk Assessment
Consent Determination

On-going Services

Social Work Counseling
Physical Therapy
Occupational Therapy
Speech Therapy
Psychiatry
Vocational Rehabilitation Counseling

Required Documentation for one-time services:

-A Copy of Current Insurance Cards
- Prior Psychological Testing
* Prescription for Assessment from Primary Care Physician
(PT/OT and Dysphagia Assessment only)

Required Documentation for on-going services:

-A Copy of Current Insurance Cards
-Prior Psychological Testing
-Eligibility Determination letter
-Life Plan
-Primary Care Physician's Prescription for OT/PT