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

DATE OF 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.

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? _____

SASi Article16 Clinic Services

One-time Services
Psychological Assessment (IQ)
Psychological Assessment (Adaptive)
Autism Assessment
Sexuality Assessment
Guardianship/MedicalAffidavits
Risk Assessment
Consent Determination

On-going Services
Social Work Counseling
Physical Therapy
Occupational Therapy
Speech Therapy
Psychiatry
Vocational Rehabilitation Counseling

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:

Required Documentation for one-time services:

- All communications from OPWDD regarding eligibility
- IQ (Cognitive) testing
- For individuals over the age of 18 who have not previously been eligible for OPWDD services Retrospective ADAPTIVE BEHAVIOR ASSESSMENT
- AUTISM ASSESSMENTS
- SOCIAL HISTORY, PSYCHO-SOCIAL REPORT, or Other Background Information
- INDIVIDUALIZED EDUCATION PLAN (IEP)
- 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 LetterLife Plan
- Primary Care Physician's Prescription for OT/PT

Medical Information:

Primary Care Physician: _____ **Phone:** _____

Address: _____

Psychiatrist's Name: _____ **Phone:** _____

Primary Diagnosis: _____
Secondary Diagnosis: _____

Communication Status:
☐Verbal- Language(s) spoken:
☐Non-Verbal ☐Uses Sign Language ☐Uses Picture
☐Uses Communication Device-Type: _____ ☐Hearing Impaired
☐Deaf ☐Other (please specify): _____

Allergies? ☐YES ☐NO Known Allergies **Latex Allergy?** ☐YES ☐NO
If Yes, please list allergies and reactions to exposure:

Allergic To:	Reaction to Exposure:

Special Medical Alerts
Seizures: ☐YES ☐NO If Yes, type & duration: _____
Asthma: ☐YES ☐NO If Yes, causative factors: _____

Other special Medical Alerts (please specify)

_____
_____
_____

Diet: Swallowing Difficulty ☐YES ☐NO If Yes, please describe: _____
Food Consistency: ☐Whole ☐Soft ☐1 inch piece ☐½ inch pieces
☐¼ inch pieces ☐Ground ☐Puree
Liquid Recommendations: ☐Regular ☐Nectar ☐Honey ☐Pudding
Other: ☐Tube-Fed ☐No oral feeds ☐Taste/Pleasure feeds only

Mobility & Transfers
Transfers: ☐Independently ☐With Physical Assistance ☐With Assistive Device
Mobility: ☐Independently ☐With Physical Assistance ☐With Assistive Device

Please list any assistive devices used for mobility and transfers:

_____
_____
_____