



Please return completed application to:  
Arc of Onondaga

**Attn: Horizons Article 16 Clinic**

600 South Wilbur Avenue  
Syracuse, NY 13204

For more information, please contact Barry Lyon, Treatment Coordinator at 476-7441 ext. 111  
or email at [blyon@arcon.org](mailto:blyon@arcon.org). Fax transmissions may be sent to 476-1582

## Horizons Article 16 Clinic Application

Applicant's Name : \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Medicaid No. \_\_\_\_\_ Medicare No. \_\_\_\_\_

Third Party Insurance No. \_\_\_\_\_ **(SUBMIT COPIES OF ALL CARDS)**

Person completing application/relationship to applicant: \_\_\_\_\_

Name of Service Coordinator: \_\_\_\_\_ Agency: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ Email: \_\_\_\_\_

### Type of Residence (please check):

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Alone            | <input type="checkbox"/> Parents or member of his/her family | <input type="checkbox"/> OMRDD/Agency Residence |
| <input type="checkbox"/> Homeless/Shelter | <input type="checkbox"/> Family Care Provider                | <input type="checkbox"/> Friends/Housemates     |
| <input type="checkbox"/> DSS/Foster Care  | <input type="checkbox"/> Other (please specify)              |   |

Name of Residential Contact/Address/Phone: \_\_\_\_\_

**Does applicant have a legal guardian?**  Yes (see \*\*\* below)  No

Name of legal guardian: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Address: \_\_\_\_\_ Email: \_\_\_\_\_

Street City Zip

May Arc of Onondaga contact you with Agency updates and information? Yes  No

**\*\*\* If the person has a legal guardian the Guardian must be notified of the referral being made and copies of Guardianship affidavit must be submitted with referral.**

### Medical Information

Primary Care Physician's name: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Address: \_\_\_\_\_

Psychiatrist's Name: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Allergies: \_\_\_\_\_ Hep B Carrier:  Yes  No

List of Medications: \_\_\_\_\_

Seizure History (include type, frequency, date of last known seizure): \_\_\_\_\_

**Physical Limitations:** \_\_\_\_\_

\*\*\* **Is the consumer currently receiving any other Article 16 Clinic Services?** Yes  No

If so on-going appointments **must not** occur on the same day at two different Article 16 Clinics.

Is the consumer receiving any other of the following services: **Psychology, Psychiatry, Social Work, Rehabilitation Counseling, Nursing, Nutrition, Occupational, Aquatic, or Physical Therapy?** If so please include Agency name, address, and phone number/contact. This information is requested to avoid duplication of service.

\_\_\_\_\_  
\_\_\_\_\_

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**Services Requested:**

- |   |   |
|---|---|
| <input type="checkbox"/> Psychological Assessment ( <b>IQ</b> )               | <input type="checkbox"/> Social Work Counseling               |
| <input type="checkbox"/> Psychological Assessment ( <b>Adaptive Testing</b> ) | <input type="checkbox"/> Rehabilitation/Vocational Counseling |
| <input type="checkbox"/> Psychological Evaluation ( <b>counseling</b> )       | <input type="checkbox"/> Nutritional Counseling               |
| <input type="checkbox"/> Guardianship/Medical Affidavits                      | <input type="checkbox"/> Physical Therapy                     |
| <input type="checkbox"/> Sexuality Assessment                                 | <input type="checkbox"/> Occupational Therapy                 |
| <input type="checkbox"/> Nursing Services                                     |   |

\*\*\*Please Note: One must be attending one of Arc's Day Habilitation Programs at Galeville, Lakeshore, Fremont, Salina or Hampton in order to receive OT or PT services.

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**Site Attending:**

- |   |  |
|---|--|
| <input type="checkbox"/> East Syracuse Day Habilitation | <input type="checkbox"/> Galeville .D.H. |
| <input type="checkbox"/> North Midler Day Habilitation  | <input type="checkbox"/> Lakeshore D.H.  |
| <input type="checkbox"/> Onondaga Day Habilitation      | <input type="checkbox"/> Fremont .D.H.   |
| <input type="checkbox"/> Monarch (Wilbur Site)          | <input type="checkbox"/> Salina D.H.     |
| <input type="checkbox"/> Monarch (Wavel Site)           | <input type="checkbox"/> Hampton .D.H.   |

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**Briefly describe the individual's need for service and any special interests, issues or concerns:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature of person completing form \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

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**FOR OFFICE USE ONLY**

I have reviewed all of the medical documents requested and forwarded to the clinic related to the care of this consumer and give my approval for the service(s) requested.

Approval signature of Medical Director \_\_\_\_\_,MD Date: \_\_\_\_\_

Clinic Treatment Coordinator: \_\_\_\_\_ Date: \_\_\_\_\_