Complete SLP, OT, PT & Psychology Services PLLC
3410 Grace Avenue ■ Bronx, NY 10469 ■ Phone: 646-8976963 ■ Fax: 646-786-4458 ■ E-Mail: kstevens@cmptherapyservices.com

Requirements for New Individuals to the IPSIDD/INDEPENDENT Program

- ☐ Individual Face Sheet (includes: Patient Consent for Examination and Treatment) to be signed by authorized family member or guardian
- ☐ Financial Agreement
- ☐ Scripts: May be procured from the NP Visits practice or the PCP of the consumer. OT and PT scripts are mandatory. Cognitive psychology and speech therapy scripts are optional.

Please also provide the following documents/information:

- ☐ Copy of Medicaid/Medicare Card
- ☐ Copy of Private Insurance Card (Front and Back) with Subscriber's Name, Date of Birth and Social Security Number
- ☐ Copy of Guardianship documents (if applicable)
- ☐ Copy of Health Care Proxy/other Advance Directive (if applicable)
- ☐ Copies of Current Physical and Laboratory Work (if available)
- ☐ List of Current Medications
- ☐ Copies of Psychiatric, Psychological, Psychosocial Evaluations (if available)
- ☐ Copies of Life Plan (most recent on file if available

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Multi Practitioner's Group statement:
We would appreciate the prompt completion of this packet. Please log on to patient portal, or scan and email, or fax in or copy and mail items immediately to the assigned Intake Coordinator.

Name of Group	Complete SLP, OT, PT & Psychology Services, PLLC :
Attn:	Crystal Stephenson, Operations Manager
Address	3410 Grace Avenue
Address	Bronx, NY 10469
Phone	(O) 646-897-6963 (C) 917-570-8971
Fax	646-786-4458
Email	cstephenson@cmptherapyservices.com
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IPSIDD/INDEPENDENT SERVICES REFERRAL FACE SHEET

Name (last, first)	
DOB	
Medicaid #	
Full address of Treatment Location. (Specify: Group Home, Private Home, Day Hab, Other)	
Treatment Location Contact's Name/Relationship	
Contact's email	
Contact's best phone #	
Name, email, phone of Care Manager. (Specify which CCO)	
Referred to IPSIDD program for: □ OT	To improve impaired fine motor skills, upper extremity strength, ameliorate cognitive impairments (via ADLs, money management)
Referred to IPSIDD program for: □ PT	To increase endurance to gait, ambulation, stair climbing, wheelchair/walker management, upper and lower body strength
Referred to IPSIDD program for: □ ST	Ameliorate effects of expressive and receptive language disorders, swallowing disorders, sign language to indicate needs and wants
Referred to IPSIDD program for: □ Psychotherapy	Cognitive (not behavioral) psychotherapy based on a Treatment Plan drawn up with input from staff, team and client
Psychosocial Evaluation □	Psychosocial evaluation being requested
Referred to Independent Services for □ Nutrition	Nutritional counseling, reduce BMI, menu's, recipes, exercise program suggestions, staff education.
Referred to IPSIDD program for: □ Podiatry Therapy	

CONSENT/RELEASE STATEMENT

I am consenting to receive IPSIDD clinical services from the above Multi Practitioner Groups.
I authorize any holder of medical information about me to release to the Group's Claims Administrators any information needed to determine these benefits or the benefits payable for related services.
I hereby assign and authorize payment directly to the above Multi Practitioner Groups of any benefits due because of liability or responsibility of a third party, including an insurance company, workers compensation, disability, or federal or state payer.

❑ Individual is unable to sign. Responsible party is completing the below on individual's behalf	
Individual or Representative Print name	
Title/Relationship to individual	
Signature	
Date of consent	