Complete SLP, OT, PT, Psychology & Adult Health NP Services, PLLC
3410 Grace Ave, Bronx New York, 10469• Phone: 646-8976963 • Fax: 646-786-4458
• E-Mail: kstevens@cmptherapyservices.com

Requirements for Individuals to the IPSIDD/INDEPENDENT Program

- ☐ Individual Face Sheet (includes: Patient Consent for Examination and Treatment. Pls select all for authorization to treat) to be signed by authorized family member or guardian
- ☐ Financial Agreement
- ☐ Scripts: May be procured from the CMP NP 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
- ☐ Pls specify in your email the services that you are currently requesting

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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 & Adult Health NP 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

*Additional Intake forms can be found on our website:
https://cmptherapyservices.com/
(scroll down to Service Request Form)
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IPSIDD/INDEPENDENT SERVICES REFERRAL FACE SHEET

Name (last, first):	
Date of Birth:	
Medicaid CIN #:	
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 & Swallow Function	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 DPP/CDM	DPP/CDM counseling, reduce BMI, exercise program suggestions, meal prep guidance & staff education.
Referred to Independent Services for Equipment Recommendation	Recommend adaptive equipment to support daily living skills, mobility and positioning aids and adaptive communication devices

Purpose of Consent

I hereby give my informed consent for the individual named above to receive the following IPSIDD services from a licensed and approved provider:

☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy ☐ Swallow/Feeding Eval

☐ Psychology / Counseling ☐ DPP/CDM ☐ Equipment Recommendation

☐ Other: _____

These services will be delivered:

☐ In the individual's certified residence

☐ In a certified day program

☐ Via telehealth (as permitted)

☐ At another OPWDD-approved location: _____

CONSENT/RELEASE STATEMENT

I hereby consent to receive treatment and care from Complete SLP, OT, PT, Psychology & Adult Health NP Services, PLLC across all applicable disciplines, as determined necessary by my healthcare provider(s).

I acknowledge that:

- The above services are designed to improve the individual's health, independence, and quality of life. I understand that participation is voluntary and that services may involve physical activities, personal discussions, or therapeutic exercises. Potential benefits and risks have been explained.
- I have the right to ask questions and seek clarification regarding any proposed treatment.
- I may withdraw this consent at any time by providing written notice, except to the extent that treatment has already been provided.
- This consent remains in effect unless revoked by me in writing.

By signing below, I acknowledge that I have read and understood this consent and voluntarily agree to treatment as outlined above.

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 authorize the provider to release and/or obtain necessary medical, therapeutic, or educational information from relevant parties (e.g., physicians, OPWDD programs, Medicaid, school or day programs) for the purposes of diagnosis, treatment, coordination of care. 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.

Consent Validity

☑ This consent is valid for one (1) year from the date signed below.
☑ I understand that I may withdraw consent at any time by providing written notice.

☐ The individual has capacity and is voluntarily consenting. ❑ 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	

Internal Use Only (Completed by Provider)
Provider Name: _____
Date of Intake: _____
Service(s) Requested: _____
☐ Consent form uploaded to EHR ☐ Verified with residential agency
☐ Annual consent reminder set