Dear Parent/Caregiver:

Thank you for your interest in the Therapeutic Day Program Outpatient Therapy Clinic. Enclosed you will find the admission application which includes:

Application Checklist

	Form/Assessment/Records	**Completed/Provided By**
	Admission Assessment (4 pages)	Parent/caregiver
	UCLA PTSD Reaction Index (2 pages)	Parent/caregiver
	Insurance Coverage & Financial Worksheet	Parent/caregiver
	Release of information form **Primary Care Provider** (1 page)	Parent/caregiver
	Release of information for **School/daycare** (1 page)	Parent/caregiver
	Parent's online assessment *(link provided via email from TDP)*	Parent/caregiver
	Teacher's email address *(if seeing behaviors in school)*	Parent/caregiver
	School Info Request (2 pages) *(if seeing behaviors in school)*	Teacher, school, daycare
	School Behavior Intervention Plan (2 pages) *(if seeing behaviors in school)*	Teacher, school, daycare
	Teacher's online (*link provided via email from TDP) (if seeing behaviors in school)*	Teacher, school, daycare

Additional Information Needed

- Custody/adoption/guardianship paperwork *(if applicable)*
- Copy of current insurance card
- Any other supporting documentation such as an IEP, psychological evaluation/testing, speech/language evaluation, records from any other behavioral health providers.

If you have any additional questions, please do not hesitate to contact me.

We look forward to working with you and your child.

Sincerely,

Cindy DiNicolas
Administrative Assistant
cynthia.dinicolas@advocatehealth.org
O: 336.713.7497
F: 336.702.9199

Therapeutic Day Program Outpatient Therapy Admission Assessment

Childs Full Name: _____

Date of Birth: _____ Race: _____ Gender: _____

Social Security Number: _____

Mothers' Name: _____ Date of Birth: _____

Fathers' Name: _____ Date of Birth: _____

Name and address of person with whom the child resides (include street, city, and zip code):

_____

_____

_____

County of Residence: _____ Home Phone: _____

Email Address: _____

Parents (check one): ☐ Married ☐ Unmarried ☐Separated ☐ Divorced ☐ Widowed

Who has legal custody of the child? _____

Please list all persons living in child's home and their date of birth:

_____

_____

_____

Mothers' occupation: _____ Mothers' work phone: _____

Mothers' employer: _____ Highest school grade completed: _____

Fathers' occupation: _____ Fathers' work phone: _____

Fathers' Employer: _____ Highest school grade completed: _____

INSURANCE INFORMATION:

Child's Insurance Provider: _____

If Medicaid, list what type of Medicaid and Medicaid number: _____

_____

PRE-SCHOOL/SCHOOL HISTORY

Does your child attend daycare, preschool, or school? _____ If yes, list name and address of program and how long child has been enrolled: _____
_____

Does child receive any special therapies or services (i.e., speech therapy, early intervention, other?) _____
If so, explain: _____
_____

Does your child have an IEP? _____ Has the IST process started? _____ **(If your child has an IEP, kindly provide the program with a copy)**

Do you think your child needs additional support in school? _____ If so, explain: _____
_____
_____
_____

BIRTH/MEDICAL HISTORY

Were there problems during the pregnancy, labor, or delivery? _____ If so, explain: _____
_____

How many weeks or months was the pregnancy? _____ Baby's birth weight: _____

Birth was (check one): ☐ Normal ☐ Cesarean ☐ Breech ☐ Twins or more

Did baby have problems after birth? _____ If yes, please explain: _____
_____

Please list any major illnesses or injuries your child has had to this date: _____
_____

Is your child taking any medications regularly? _____ If yes, please list: _____
_____

Child's Primary Care Physician (Name/Address/Phone): _____
_____

List any other doctors/evaluators who have treated your child (Include name/address/phone): _____
_____
_____

Has your child ever been hospitalized? _____ If so, where? _____
Reason for hospitalization? _____
_____

DEVELOPMENTAL HISTORY

At what age did your child roll over _____ Sit Alone _____ Pull up to furniture _____ Crawl _____ Walk _____
Say Single Words _____ Say 3-word sentences _____ Become Toilet Trained _____

PLEASE CHECK THE AREAS THAT CURRENTLY CONCERN YOU ABOUT YOUR CHILD

GROSS MOTOR SKILLS:
☐Running ☐ Climbing unassisted ☐ Pedaling a tricycle ☐ Jumping with good balance ☐ Using stairs alternating feet ☐ Balancing on one foot ☐ Kicking a ball ☐ Throwing a ball overhead ☐ Sliding unassisted

FINE MOTOR SKILLS:
☐ Holding a pencil ☐ Copying (lines/circles) ☐ Using scissors ☐ Opening wrappers

SELF-HELP SKILLS:
☐ Using both spoon/fork ☐ Toileting independently ☐ Undressing independently ☐ Dressing independently ☐ Washing/Drying hands independently

STRENGTH AND MUSCLE TONE:
☐ Loses balance ☐ Clumsy ☐ Can't hold sitting position on floor for 5 minutes ☐ Muscles too tight ☐Muscles too loose

SENSITIVITIES:
☐ Avoids certain clothing items ☐ Avoids certain foods/smells ☐Picky eater ☐ Wears clothes incorrectly ☐ Becomes frightened when feet leave the ground ☐ Avoids going barefoot ☐ Bothered by certain noises (specify noise): _____

SEEKS SENSATION:
☐ Chews clothes ☐ Enjoys/Makes strange noises ☐ Can't sit still/Fidgets ☐ Becomes overly excited during activities ☐ Touches people/objects ☐ Doesn't notice when hands/face are messy

LISTENING SKILLS:
☐ Hears what is being said ☐ Difficulty paying attention ☐ Easily distracted by noise in immediate setting

COGNITIVE LEARNING:
☐ Understanding positive/negative consequences ☐ Following/understanding rules ☐ Stops and thinks before acting ☐ Learns new concepts ☐ Remembering what they have learned ☐ Distinguishing between reality/fantasy (understands what is real and what is pretend

ATTENTION/ACTIVITY LEVEL:
☐ Overly Active ☐ Low energy/underactive ☐ Appears in own world ☐ Short attention span

SOCIAL/EMOTIONAL:
☐ Expressing feelings verbally: ☐ Happy ☐ Sad ☐ Angry ☐ Afraid
☐ Naming/Identifying a friend ☐ Limited range of activities/toys ☐ Odd/Intense interests ☐ Engaging in cooperative play ☐ Engaging in imaginary/pretend play ☐ Little interest in peers ☐ Little interest in adults

OTHER:
☐ Accepts transitions ☐ Insists on routines ☐ Difficulty separating from family members ☐ Repeats questions when answers are provided ☐ Appears worried ☐ Often complains of not feeling well ☐ Likes things a certain way ☐ Does not like when play items are moved ☐ Speaks less in group settings ☐ Often appears irritable ☐ Mood changes frequently ☐ Unaware of danger ☐ Sleep problems

REFERRAL CONCERNS:

What are your primary concerns about your child? _____
_____

What have you been told regarding these concerns? (by your child's doctor, etc.) _____
_____
_____

Has your child received a behavioral or medical diagnoses? _____ If yes, please note: _____
_____
_____

What would you like to see done for your child during this admission? _____
_____
_____
_____

How can this program support you as a parent/caregiver? _____
_____
_____
_____

Who referred you to the Therapeutic Day Program Outpatient Therapy Clinic?_____
_____

Name of person completing this form: _____

I do hereby give my permission, as this child's parent/guardian, to have him/her treated/evaluated by the Therapeutic Day Program Outpatient Therapy Clinic. I understand that this facility is both a service and a training program and give my consent to have fully-supervised students participate in the evaluation.

Parent/Guardian (Print Name): _____
Signature: _____ Date: _____

Please return completed forms to the administrative assistant by fax at 336-702-9199 or by email at cynthia.dinicolas@advocatehealth.org.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Information: I give permission to release the health information of: **(One Patient Per Form)**

Patient Name: _____ Date of Birth: _____

Street Address: _____ City, State, Zip: _____

Telephone: ( ) _____ Email Address: _____

By providing your email address you acknowledge and accept the risks outlined in the Guidelines for Electronic Communications posted on atriumhealth.org.

Release Information From:

(Primary Care Provider)
(List applicable Facility(s) and/or Practice(s)

(Phone number) (Fax number)

Release Information To:

AHLC Theraputic Day Program Outpatient Therapy Clinic
(Name of facility, person, company) (Relationship)

231 Melrose St, Winston-Salem, NC 27103
(Street Address or PO Box, City, State, Zip Code)

336-713-7497 336-702-9199
(Phone number) (Fax number)

PURPOSE OF RELEASE (check reason): ☐ Request of individual/personal rep ☒ Continued patient care ☐ Insurance
☐ Legal purpose including discussions & proceedings ☐ Other _____

Fill in dates of treatment for records to be released:
Treatment dates: From Within the past 12 months **To** _____

Medical Records (check all that may apply):

- ☐ Facility Summary (includes items in **bold**)
- ☒ **Discharge Summary**
- ☐ **History and Physical**
- ☐ **Consultation Reports**
- ☒ **Office/Home Visits**
- ☐ **Emergency Record**
- ☐ **Operative Reports**
- ☐ **Laboratory Reports**
- ☐ **Pathology Reports**
- ☐ **Radiology/X-Ray Reports**
- ☒ **Immunizations**
- ☒ Therapy Notes (Occupational/Physical/Speech)
- ☐ Sleep Study Reports
- ☐ Entire Medical Record (Does not include billing or imaging)
- ☐ Other: _____

Imaging (requires CD format):

- ☐ Radiology Images
- ☐ Cardiology Images (Echo, Cath Lab)
- ☐ Neurology Images (EEG)
- ☐ OBGYN Ultrasound
- ☐ Other Imaging: _____

Billing:

- ☐ Itemized Bill(s)
- ☐ UB04 Form
- ☐ CMS 1500 Form
- ☐ Other Billing: _____

FORMAT:

- ☐ CD (charges may apply)
- ☒ Email Address noted above, where permitted
- ☐ Paper copy (charges may apply)
- ☒ Other Fax

DELIVERY METHOD:

- ☐ Reg.US Mail ☒ Fax, where permitted
- ☐ Pick-up, at the following facility: _____
- ☒ Secure email
- ☐ Other: _____

PATIENT'S RIGHTS – I understand that:

- **I can cancel this permission at any time. I must cancel in writing and send or deliver cancellation to releasing facility or practice named above. Any cancellation will apply only to information not yet released by facility or practice.**
- **This is a full release including information related to behavioral/mental health, drug and alcohol abuse treatment (in compliance with 42 CFR Part 2), genetic information, HIV/AIDS, and other sexually transmitted diseases.**
- **Once my health information is released, the recipient may disclose or share my information with others and my information may no longer be protected by federal and state privacy protections. Records protected by 42 CFR Part 2 may not be redisclosed without my additional consent**
- **Refusing to sign this form will not prevent my ability to get treatment, payment, enrollment in health plan, or eligibility for benefits.**
- **Atrium Health will not share or use my health information without my permission other than by ways listed in the Notice of Privacy Practices or as required by law. The Notice of Privacy Practices is available at atriumhealth.org.**
- **I have a right to a copy of this Authorization.**

This permission expires one year after the date of my signature unless another date or event is written here: _____

Signature: _____ **Print Name:** _____ **Date:** _____

Note: If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this form.
Note the relationship/authority if signature is not that of the patient (Written proof MAY be requested):

☐ **Healthcare Agent/POA** ☒ **Guardian** ☐ **Executor/Administrator/Attorney in Fact** ☐ **Spouse**
☒ **Parent** ☐ **Adult Child** ☐ **Affidavit Next of Kin** ☐ **Other:** _____

Note: If minor consented to a licensed physician for their treatment for pregnancy, sexually transmitted disease, outpatient behavioral/mental health, or outpatient treatment of controlled substances or alcohol without parental consent, the minor must sign this authorization. When the patient is a minor being treated for a substance use disorder and the parent or guardian consented for such treatment, both the minor and parent or guardian must sign this authorization.

Signature of Minor: _____ **Print Name:** _____ **Date:** _____

Date of release: _____ via ☐Mail ☐Fax ☐Other _____ ☐**ID Verified** ☐**DL/Other ID** _____
Atrium Health Teammate Name & Department. : _____ **Date:** _____ **# of Pages** _____

Place Patient Label Here

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Information: I give permission to release the health information of: **(One Patient Per Form)**

Patient Name: _____ Date of Birth: _____

Street Address: _____ City, State, Zip: _____

Telephone: ( ) _____ Email Address: _____

By providing your email address you acknowledge and accept the risks outlined in the Guidelines for Electronic Communications posted on atriumhealth.org.

Release Information From:

_____ (school/daycare)
(List applicable Facility(s) and/or Practice(s)

_____

_____
(Phone number) (Fax number)

Release Information To:

AHLC Therapeutic Day Program Outpatient Therapy Clinic
(Name of facility, person, company) (Relationship)

231 Melrose St, Winston-Salem, NC 27103
(Street Address or PO Box, City, State, Zip Code)

336-713-7497 336-702-9199
(Phone number) (Fax number)

PURPOSE OF RELEASE (check reason): ☐ Request of individual/personal rep ☒ Continued patient care ☐ Insurance
☐ Legal purpose including discussions & proceedings ☐ Other _____

Fill in dates of treatment for records to be released:
Treatment dates: From Within the past 12 months **To** _____

Medical Records (check all that may apply):

- ☐ Facility Summary (includes items in **bold**)
- ☐ **Discharge Summary**
- ☐ **History and Physical**
- ☐ **Consultation Reports**
- ☐ **Office/Home Visits**
- ☐ **Emergency Record**
- ☐ **Operative Reports**
- ☐ **Laboratory Reports**
- ☐ **Pathology Reports**
- ☐ **Radiology/X-Ray Reports**
- ☐ **Immunizations**
- ☐ Therapy Notes (Occupational/Physical/Speech)
- ☐ Sleep Study Reports
- ☐ Entire Medical Record (Does not include billing or imaging)
- ☒ Other: All school records

Imaging (requires CD format):

- ☐ Radiology Images
- ☐ Cardiology Images (Echo, Cath Lab)
- ☐ Neurology Images (EEG)
- ☐ OBGYN Ultrasound
- ☐ Other Imaging: _____

Billing:

- ☐ Itemized Bill(s)
- ☐ UB04 Form
- ☐ CMS 1500 Form
- ☐ Other Billing: _____

FORMAT:

- ☐ CD (charges may apply)
- ☒ Email Address noted above, where permitted
- ☐ Paper copy (charges may apply)
- ☒ Other Fax

DELIVERY METHOD:

- ☐ Reg.US Mail ☒ Fax, where permitted
- ☐ Pick-up, at the following facility: _____
- ☒ Secure email
- ☐ Other: _____

PATIENT'S RIGHTS – I understand that:

- **I can cancel this permission at any time. I must cancel in writing and send or deliver cancellation to releasing facility or practice named above. Any cancellation will apply only to information not yet released by facility or practice.**
- **This is a full release including information related to behavioral/mental health, drug and alcohol abuse treatment (in compliance with 42 CFR Part 2), genetic information, HIV/AIDS, and other sexually transmitted diseases.**
- **Once my health information is released, the recipient may disclose or share my information with others and my information may no longer be protected by federal and state privacy protections. Records protected by 42 CFR Part 2 may not be redisclosed without my additional consent**
- **Refusing to sign this form will not prevent my ability to get treatment, payment, enrollment in health plan, or eligibility for benefits.**
- **Atrium Health will not share or use my health information without my permission other than by ways listed in the Notice of Privacy Practices or as required by law. The Notice of Privacy Practices is available at atriumhealth.org.**
- **I have a right to a copy of this Authorization.**

This permission expires one year after the date of my signature unless another date or event is written here: _____

Signature: _____ **Print Name:** _____ **Date:** _____

Note: If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this form.
Note the relationship/authority if signature is not that of the patient (Written proof MAY be requested):

☐ **Healthcare Agent/POA** ☒ **Guardian** ☐ **Executor/Administrator/Attorney in Fact** ☐ **Spouse**
☒ **Parent** ☐ **Adult Child** ☐ **Affidavit Next of Kin** ☐ **Other:** _____

Note: If minor consented to a licensed physician for their treatment for pregnancy, sexually transmitted disease, outpatient behavioral/mental health, or outpatient treatment of controlled substances or alcohol without parental consent, the minor must sign this authorization. When the patient is a minor being treated for a substance use disorder and the parent or guardian consented for such treatment, both the minor and parent or guardian must sign this authorization.

Signature of Minor: _____ **Print Name:** _____ **Date:** _____

Date of release: _____ via ☐Mail ☐Fax ☐Other _____ ☐**ID Verified** ☐**DL/Other ID** _____
Atrium Health Teammate Name & Department. : _____ **Date:** _____ **# of Pages** _____

Place Patient Label Here

Revised 8/2025

Therapeutic Day Program Outpatient Therapy Insurance Coverage/Financial Worksheet

Clients Name: _____ DOB:_____ SS#:_____

INSURANCE COVERAGE:

Medicaid Insurance *(if applicable)*
Type of Medicaid *(i.e., WellCare, UnitedHealthcare, etc.)*_____
Medicaid ID:_____

Private Insurance *(if applicable)*
Insurance Company (name/address/phone)_____
_____
Policy holder's Name:
_____
Employer: _____
Policy/ID #: _____
Group Number: _____

FINANCIAL WORKSHEET: ***(for anonymous United Way statistical reporting only; identifying information provided will not be shared)***

Name of people living in client's household *(including client)*

Name	Relationship to client

Name of current monthly income sources for household *(i.e., job, child support, government assistance, etc.)*	Monthly Income amount *(after taxes)*	Multiply x 12 = Est. Total Yearly Household Income
Estimated Total Yearly Household Income		

ELIGIBILITY FOR OTHER PROGRAMS: ***(check all that apply)***
___ SSI/ Eligibility Date: _____ ___ Medicaid/Eligibility Date: _____

Parent/guardian signature: _____ Date: _____

Please return completed forms to the administrative assistant by fax at 336-702-9199 or email at cynthia.dinicolas@advocatehealth.org

Therapeutic Day Program Outpatient Therapy School Information Request

(To be completed by school or daycare staff)

Child's Name: _____ **DOB:** _____

The parent/guardians of the above-named child are interested in admitting their child to the Therapeutic Day Program Outpatient Therapy Clinic. Your responses to the following questions are an essential component to the evaluation for admission and will be greatly appreciated.

School name, address, phone:_____

_____

Hours of attendance:_____

Teacher Name:_____

Number of students in class:_____

Grade/Age Range:_____

Number of adults (teachers, aides, volunteers) available for supervision of these children? _____

Does this child have an active IEP in place? _____ *(If so, please provide a copy)*

What concerns do you have of this child at this present time? (*Please list in order of concern)*

1. _____
2. _____
3. _____
4. _____

Was an Instructional Support Team (IST) referral initiated? _____ *(If so, please provide a copy of referrals made to the IST Team)*

What interventions have been implemented to address the above-noted behaviors and found unsuccessful (e.g., functional behavioral assessment/plan, IEP, 504 plan, behavior plans)? *(Please provide copies of these interventions, verifying implementation)*

_____

_____

_____

_____

_____

_____

What contact have you had with parents? _____

Has the child received a developmental evaluation? _____ **If yes, by whom?** _____

PLEASE CHECK ALL AREAS OF CURRENT CONCERN

Gross Motor Skills: ☐Running ☐ Climbing unassisted ☐ Pedaling a tricycle ☐ Jumping with good balance ☐ Using stairs alternating feet ☐ Balancing on one foot ☐ Kicking a ball ☐ Throwing a ball overhead ☐ Sliding unassisted

Fine Motor Skills: ☐ Holding a pencil ☐ Copying (lines/circles) ☐ Using scissors ☐ Opening wrappers

Self-Help Skills: ☐ Using both spoon/fork ☐ Toileting independently ☐ Undressing independently ☐ Dressing independently ☐ Washing/drying hands independently

Strength and Muscle Tone: ☐ Loses balance ☐ Clumsy ☐ Can't hold sitting position on floor for 5 minutes ☐ Muscles too tight ☐Muscles too loose

Sensitivities: ☐ Avoids certain clothing items ☐ Avoids certain foods/smells ☐Picky eater ☐ Wears clothes incorrectly ☐ Becomes frightened when feet leave the ground ☐ Avoids going barefoot ☐ Bothered by certain noises (specify noise): _____

Seeks Sensation: ☐ Chews clothes ☐ Enjoys/makes strange noises ☐ Can't sit still/fidgets ☐ Becomes overly excited during activities ☐ Touches people/objects ☐ Doesn't notice when hands/face are messy

Listening Skills: ☐ Hears what is being said ☐ Difficulty paying attention ☐ Easily distracted by noise in immediate setting

Cognitive Learning: ☐ Understanding positive/negative consequences ☐ Following/understanding rules ☐ Stops and thinks before acting ☐ Learns new concepts ☐ Remembering what they have learned ☐ Distinguishing between reality/fantasy (understands what is real and what is pretend)

Attention/Activity level: ☐ Overly Active ☐ Low energy/underactive ☐ Appears in own world ☐ Short attention span

Social/Emotional: ☐ Expressing feelings verbally (☐ Happy ☐ Sad ☐ Angry ☐ Afraid) ☐ Naming/Identifying a friend ☐ Limited range of activities/toys ☐ Odd/Intense interests ☐ Engaging in cooperative play ☐ Engaging in imaginary/pretend play ☐ Little interest in peers ☐ Little interest in adults

Other: ☐ Accepts transitions ☐ Insists on routines ☐ Difficulty separating from family members ☐ Repeats questions when answers are provided ☐ Appears worried ☐ Often complains of not feeling well ☐ Likes things a certain way ☐ Does not like when play items are moved ☐ Speaks less in group settings ☐ Often appears irritable ☐ Mood changes frequently ☐ Unaware of danger ☐ Sleep problems

Signature: _____ Date: _____

Title: _____

Please return completed forms to the administrative assistant by fax at 336-702-9199 or by email at cynthia.dinicolas@advocatehealth.org.

Therapeutic Day Program Outpatient Therapy School Behavior Intervention Plan (BIP)

School/Daycare Name: _____
Child's Name: _____
Name/Title of Person Completing Form: _____

Describe Problem Behavior(s):

Problem Behavior (*Aggression, Disrupting Class, Elopement/Running from Room)*	**How Often/Frequency**	**How Long/Duration**	**Data** *(Include collection methods/source dates)*
1.			
2.			
3.			

Antecedents *(summarize what happens <u>BEFORE</u> each identified behavior)*

____ Lack of Social Attention ___ Demand Request ____ Difficult Task ____ Transition
____ Interruption/Change in Routine _____ Consequences Imposed
____ Other/Describe _____
_____
_____

Describe Behavioral Interventions Used: *(proximity to teacher, reward program, modified –shortened day, 1:1 instruction/attention)*

_____
_____
_____
_____
_____

Describe Child's Current Response to Interventions Used:

_____
_____
_____
_____
_____

General Impression of Behavior: *(why would this child benefit from a therapeutic setting)*

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Contact the Therapeutic Day Program Outpatient Therapy Clinic director at 336-713-7443 with any questions regarding the completion of this form.

Please return completed forms to the administrative assistant by fax at 336-702-9199 or by email at cynthia.dinicolas@advocatehealth.org.