

Helping Hands Therapy Service Request Form

In order for us to better assist you with your therapy needs, please provide the following information:

Organization's Name: _____
Phone: _____
Fax: _____
Address: _____

Which of the following categories does your facility or group fall into?

- School looking for ongoing therapy services to students
 - SNF converting from in-house to contract
 - SNF with a very large skilled Medicare program
 - SNF with a smaller skilled Medicare program
 - Hospital group with a mix of therapy settings (acute, swing, outpatient, etc.)
 - Home health agency looking for a long-term therapy partner
 - Other type of facility looking for ongoing therapy services (describe below)
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Which of the following therapy services does your facility or group need?

- Physical Therapy Projected # of therapist(s) needed: _____
- Occupational Therapy Projected # of therapist(s) needed: _____
- Speech Therapy Projected # of therapist(s) needed: _____

Complete the following Information:

Projected Number of Clients Needing Therapy Services: _____
Name of Current Therapy Provider: _____
Current Rate with Current Provider: _____
Projected End Date with Current Contract: _____
Projected Start Date for New Contract: _____

Please mail, e-mail, or fax completed request form to:

Helping Hands Therapy

P.O. Box 3519

Meridian, MS. 39303

Fax: 601.581.3292

E-mail: admin@helpinghands-therapy.com