2020/21 Helping Hands Therapy Authorization/Referral Form
ST ONLY

Requires Parent Signature

Student Information

Child's Name:	DOB:
Social Security Number:	Medicaid Number:
Parent's Name:	Home Address:
Gender of child:	Phone Number:

School Information

School's Name:	School System/County:
Grade:	School Phone Number:
Teacher:	Case Manager:
Location for therapy treatments?: ☐ At school listed ☐ Other, please specify:	

Medical Information

Diagnosis/Exceptionality:	Medications:
Primary Physician's Name:	Clinic's Name:
Additional Information: Does child receive outpatient therapy: ☐ **Y** ☐ **N** If yes, where:	

Parent or Legal Guardian:

- I give Helping Hands Therapy permission to treat my child.
- I give permission to bill Medicaid for therapy services if applicable and to obtain/share medical information on my child with our physician listed.

Signature _____ **Date**_____

Contact: **Caseload Coordinator**
● Phone: **334/624-3950** ● Fax: **334/624-3960** ● email: schools@helpinghands-therapy.com