CHILDREN'S REHABILITATION SERVICE
CLIENT/FAMILY INFORMATION

STATE OF ALABAMA
DEPARTMENT OF REHABILITATION SERVICES

CLIENT INFORMATION

Last name: _____ First: _____ Middle:_____Suffix: _____

Sex: - Primary Race -_____Secondary Race: -_____

Primary Language: - Secondary language: -

Hispanic origin: ◯Yes ◯No Country of Hispanic origin: -_____

Street Address:_____City:_____

State:_____ZIP code:_____County of residence:_____ Home phone: (____)____-_____

Mailing address:_____City:_____State:_____ZIP:_____

E-mail address: _____

If student, name of school:_____

Is client married:◯Yes ◯No Receives Supplemental Security Income (SSI):◯Yes ◯No ◯Applied

FAMILY INFORMATION (Parents, Spouse, Guardian)

1. Last name: _____First:_____ MI:_____ Suffix:_____

Relationship to client:_____Email:_____

Is this the person financially responsible for the client: ◯Yes ◯No

Work phone: (____)_____-_____Cell phone: (____)_____-_____Birthdate:____/____/_____

Address and home phone number same as client: ◯Yes ◯No If no, please provide below:

Street:_____City:_____

State:_____ZIP code:_____Home phone: (____)_____-_____

2. Last name: _____First:_____ MI:_____ Suffix:_____

Relationship to client:_____Email:_____

Is this the person financially responsible for the client: ◯Yes ◯No

Work phone: (____)_____-_____Cell phone: (____)_____-_____Birthdate:____/____/_____

Address and home phone number same as client: ◯Yes ◯No If no, please provide below:

Street:_____City:_____

State:_____ZIP code:_____Home phone: (____)_____-_____

3. Neighbor/Relative:_____Relationship:_____Phone: (____)_____-_____

4. Neighbor/Relative:_____Relationship:_____Phone: (____)_____-_____

CHILDREN'S REHABILITATION SERVICE
MEDICAL HISTORY INFORMATION FORM

STATE OF ALABAMA
DEPARTMENT OF REHABILITATION SERVICES

CLIENT INFORMATION

Last Name: _____ First: _____ Middle: _____ Suffix: _____

Referring Diagnosis: _____

Referred by: _____ Phone number: (___)_____-_____

Address: _____

Presenting Problem: _____

Previous Treatment/History: _____

_____

_____

_____

Current Medications and Dosage: _____

BIRTH HISTORY

Length of pregnancy: _____ Birthweight: _____

Complications:

-during pregnancy _____

-during labor/delivery _____

-after birth _____

Place of delivery: _____

Length of stay in nursery: _____

My child has/had:

☐ measles	☐ herpes	☐ heart problems	☐ learning problems
☐ mumps	☐ asthma	☐ ear infections	☐ sleeping problems
☐ chicken pox	☐ CMV	☐ hearing problems	☐ others _____
☐ scarlet fever	☐ sickle cell	☐ vision problems	_____
☐ diabetes	☐ genetic testing	☐ eating problems	_____

Allergies

☐ None known

List allergies (including medications): _____

Pertinent Family Health History (Mother's and father's family, if known)

_____

_____

_____

Other family members known to CRS: _____

_____

The above information is true to the best of my knowledge. I understand that I will be required to submit financial and insurance information each year that my child receives treatment through Children's Rehabilitation Service.

Date: _____ Signature: _____

CHILDREN'S REHABILITATION SERVICE
MEDICAL/DENTAL PROVIDER INFORMATION FORM

STATE OF ALABAMA
DEPARTMENT OF REHABILITATION SERVICES

Last name: ____________________________ First: ___________________ Middle: _______________ Suffix: _____

CLIENT'S PRIMARY PEDIATRICIAN/DOCTOR INFORMATION*

Last name: ____ First: ____________________________________

Name of clinic or practice: ____

Street: ____ City: ___________________________

State: _________________________ ZIP code: ________-_________ Office phone: (_____) _________-___________

CLIENT'S DENTAL CARE PROVIDER INFORMATION*

Last name: ____ First: ____________________________________

Name of clinic or practice: ____

Street: ____ City: ___________________________

State: _________________________ ZIP code: ________-_________ Office phone: (_____) _________-___________

CLIENT'S SPECIALTY CARE PROVIDER INFORMATION*

Provider's specialty:____

Last name: ____ First: ____________________________________

Name of clinic or practice: ____

Street: ____ City: ___________________________

State: _________________________ ZIP code: ________-_________ Office phone: (_____) _________-___________

CLIENT'S SPECIALTY CARE PROVIDER INFORMATION*

Provider's specialty:____

Last name: ____ First: ____________________________________

Name of clinic or practice: ____

Street: ____ City: ___________________________

State: _________________________ ZIP code: ________-_________ Office phone: (_____) _________-___________

CLIENT'S SPECIALTY CARE PROVIDER INFORMATION*

Provider's specialty:____

Last name: ____ First: ____________________________________

Name of clinic or practice: ____

Street: ____ City: ___________________________

State: _________________________ ZIP code: ________-_________ Office phone: (_____) _________-___________

***Please complete a Release of Information (page 7) for each provider.**

CHILDREN'S REHABILITATION SERVICE CONSENT FORM

STATE OF ALABAMA
DEPARTMENT OF REHABILITATION SERVICES

RE: _____ County:_____Last 4 SSN:_____
(Client)

I. CONSENT FOR MEDICAL CARE: I hereby give my permission and consent to the Children's Rehabilitation Service Staff, both medical and paramedical, to conduct a thorough physical examination, evaluation, and/or observation of the above-named individual, and also to request or secure any medical information and/or tests. Furthermore, I authorize the Children's Rehabilitation Service staff to provide such treatment as it shall deem is indicated by the aforementioned physical examination, evaluation, and/or observation and which is consistent with that provided by this State Agency.

II. LITIGATION SETTLEMENT: For and in consideration of Children's Rehabilitation Service examining and/or providing medical treatment or other treatment and/or services to the above-named individual, I hereby agree that the Children's Rehabilitation Service is entitled to full and complete recovery of any and all expenses and costs of services provided to the above-named individual from any and all monies received by or on behalf of the above- named individual, derived from any judgement, settlement, or any other source, the monies being received as a result of the above-named individual's injury. I hereby agree that the Children's Rehabilitation Service is entitled to a full recovery regardless of whether the above-named individual recovers the full amount of his/her loss which is caused by his/her injury. The Children's Rehabilitation Service and I hereby agree that the above will govern the rights of the parties as they relate to the recovery of monies by the above-named individual and the payment of services provided by Children's Rehabilitation Service.

III. ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize and request that all insurance benefits be paid directly to Children's Rehabilitation Service for services and items provided to the above-named individual by Children's Rehabilitation Service. I completely release the insurance company to the extent of the payment made by and to the Children's Rehabilitation Service.

IV. CIVIL RIGHTS: I have received a written statement specifying the provision of Title VI of the Civil Rights Act of 1964 (Public Law 88-352) and my right to appeal.

V. PHOTOCOPY: I agree that photocopy of this document shall be considered as effective and valid as the original.

VI. CONFIDENTIALITY: I understand that the Children's Rehabilitation Service will not disclose or release information created or received about the above-named individual except for purposes of (1) appropriate medical treatment and/or development/assessment; (2) release to insurance companies for the purpose of payment; (3) other health care operations such as review for staff monitoring and/or evaluation and for purposes of Quality Assurance monitoring. For certain other instances, I understand that I must sign an authorization permitting the disclosure or release of information.

VII. PRIVACY: I have received a written statement specifying the ADRS Notice of Privacy Practices. The Notice describes how health information about me may be used and disclosed, how I can get access to this information, and how information may be shared with me.

I certify that I understand the above statements and by signing, give consent to the above. I also understand that this consent shall remain in effect until and unless CRS is otherwise notified in writing.

_____ _____

Date Signature of Client/Parent/Guardian

DECLARATION OF CITIZENSHIP AND LAWFUL PRESENCE OF AN ALIEN FOR PUBLIC BENEFITS

Title IV of the federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 8 U.S.C. § 1621, provides that, with certain exceptions, only United States citizens, United States non-citizen nationals, non-exempt "qualified aliens" (and sometimes only particular categories of qualified aliens), nonimmigrants, and certain aliens paroled into the United States are eligible to receive state or local public benefits.

With certain exceptions, Alabama Act 2011-535 prohibits aliens unlawfully present in the U.S. from receiving state or local benefits. Every U.S. Citizen applying for a state or local public benefit must sign a declaration of Citizenship, and the lawful presence of an alien in the U.S. must be verified by the Federal Government.

Directions: All applicants must complete and submit this form. Applicant is the child or youth applying to receive services.

SECTION 1 --- APPLICANT INFORMATION

Last name: _____ First: _____ Middle:_____Suffix: _____

Current Address:_____City:_____

State:_____ZIP code:_____County of residence:_____

SECTION II --- CITIZENSHIP DECLARATION

Are you a citizen or national of the United States? (check one) ◯ Yes ◯ No

If "No," please proceed to Section III. If "Yes," proceed to signature/date.

SECTION III --- LAWFUL PRESENCE DECLARATION

Only complete this section if you answered "No" to the question above in Section II.

Are you an alien lawfully present in the United States? (check one) ◯ Yes ◯ No

SECTION IV --- DECLARATION

I declare under penalty of perjury under the laws of the State of Alabama that the answers I gave and the information I provided are true and correct to the best of my knowledge.

_____ _____

PARENT/GUARDIAN/APPLICANT'S SIGNATURE DATE

CHILDREN'S REHABILITATION SERVICE
BILLING INFORMATION FORM CLIENT

STATE OF ALABAMA
DEPARTMENT OF REHABILITATION SERVICES

Last name: _____ First: _____ Middle: _____ Suffix: _____

SSN:_____-_____-_____ Date of Birth:_____/_____/_____

Medicaid number: | | | | | | | | | | | | | |

EPSDT provider: _____

Name as it appears on the Medicaid card: _____

HEALTH INSURANCE INFORMATION

Change in health insurance within the last 12 months: ◉ Yes ○ No

Insurance company name: _____ Code: _____

Policy contract number: _____ Policy group number: _____

Effective date: From: _____ To: _____

Pharmacy benefits? ○ Yes ○ No Check if: ☐ Point of sale or ☐ Drug co-pay Dental coverage? ○ Yes ○ No

Policyholder SSN: _____-_____-_____ Insured's relationship to client: _____

Last name: _____ First: _____ MI: ____ Suffix: _____

Birthdate: _____/_____/_____ Policy holder's employer: _____

Street: _____ City: _____

State: _____ ZIP code: _____-_____ Phone: (_____) _____-_____

SECONDARY HEALTH INSURANCE

Change in health insurance within the last 12 months: ○ Yes ○ No

Insurance company name: _____ Code: _____

Policy contract number: _____ Policy group number: _____

Effective date: From: _____ To: _____

Pharmacy benefits? ○ Yes ○ No Check if: ☐ Point of sale or ☐ Drug co-pay Dental coverage? ○ Yes ○ No

Policyholder SSN: _____-_____-_____ Insured's relationship to client: _____

Last name: _____ First: _____ MI: ____ Suffix: _____

Birthdate: _____/_____/_____ Policy holder's employer: _____

Street: _____ City: _____

State: _____ ZIP code: _____-_____ Phone: (_____) _____-_____

FAMILY FINANCIAL PARTICIPATION INFORMATION

Number of persons living in household: _____

Taxable annual household income as reported on last tax return(s): _____

NOTE: Taxable annual household income should include wages of all persons in the home who support the child.

Retirement, survivor, and disability benefits may be reported in lieu of wages.

The above information is true to the best of my knowledge. I understand that I will be required to submit financial and insurance information each year that my child receives treatment through Children's Rehabilitation Service.

Date: _____ Signature: _____

CHILDREN'S REHABILITATION SERVICE
Authorization for Use, Disclosure, and/or Release of Information

STATE OF ALABAMA
DEPARTMENT OF REHABILITATION SERVICES

Child/Client Name: _____

Child/Client Address: _____

Date of Birth: _____

I give my permission to obtain and release the following protected health information about my child and/or family and communication between the individuals listed below for the purpose of treatment, medical follow up, and/or care coordination. I can revoke this permission at any time by notifying **Children's Rehabilitation Service** in writing.

I understand that a revocation is not effective to the extent that the parties named below have already relied on the authorization for use/disclosure of the protected health information.

I understand that this information may include medically sensitive material and I authorize its release for the purpose stated.

I understand that information used or disclosed related to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. **CRS will not condition treatment, payment or enrollment or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.**

Name: _____ **Name:** _____

Address: _____ **Address:** _____

City: _____ **State:** _____ **Zip:** _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax** _____ **Phone:** _____ **Fax** _____

The following written, verbal, and audio/video information may be:

□ Obtained

□ Released

For Dates of Service: _____

□ Birth records
□ Developmental Testing/Report
□ Discharge Summary
□ Enrollment Information
□ Health/Medical Records
□ Hearing Reports
□ Progress Reports
□ Psychological Testing/Reports
□ Social/Developmental History
□ Staffing Reports (IFSP/IEP)
□ Therapy/Testing Reports
□ Vision Reports
□ X-rays/Labs
□ Other: _____

This information will be used to determine eligibility and services within Children's Rehabilitation Service.

The above information is not to be released to any other individuals or agency except the one listed.

Photocopies of this Release of Information form will be considered as an original.

I understand that I have the right to refuse to sign this Release of Information.

This signed release of information form is effective from date of signature until revoked in writing by the authorized individual/s.

Parent/Guardian Name (Please Print): _____

Client/Parent/Guardian Signature: _____ **Relationship:** _____ **Date Signed:** _____