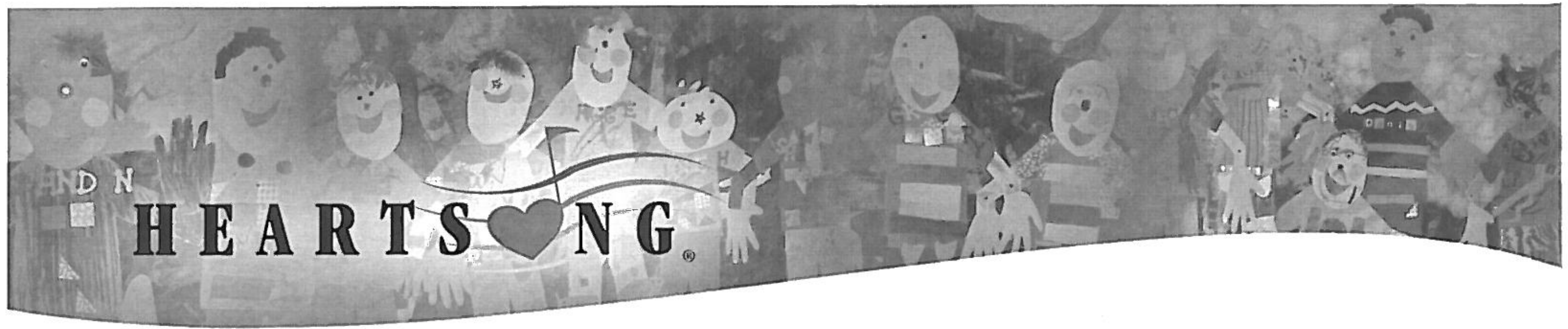


Dear Parent and/or Guardian,

Thank you for your interest in, and application to, the Heartsong program. We look forward to welcoming you and your child into our Heartsong family! To ensure the smoothest and most efficient application and interview process, we need your help in gathering important information about your child.

Before your child can participate in a placement interview, we require the following forms to be submitted to our main office:

- Application
- IEP

Please submit these two forms no later than the Wednesday, before your child's placement interview. Having this information ahead of time means that our clinical team can learn a little about your child and make the interview the best possible experience for all involved.

When your child's interview is complete, our staff turn to the important task of gathering the information and permissions necessary to ensure your child can fully participate in and enjoy the Heartsong program. Therefore, we must have the following forms on file before your child can begin the program:

- Seizure Form
- Physician Authorization Form
- School Contact Authorization Form
- Media Release Form
- Financial information (e.g., most recent Federal Income Tax Return)

After all information is gathered, we will be able to provide you with a start date for your child. If you have any questions please contact Jenna Jacobs (Program Administrative Assistant) at telephone # and email. We at Heartsong look forward to providing your child not only with the best service possible, but with fun and rewarding experiences to enhance their joy in life.

Sincerely,

The Heartsong Team

NYS Office For People With Developmental Disabilities

Putting People First

Andrew M. Cuomo, *Goverr*
Courtney Burke, *Commissior*

Hudson Valley DDS(

Michael Kirchmer, *Direc*

Westchester County Offi
220 White Plains Road, 6th Flc
Tarrytown, NY 105

TEL: 914-332-89
FAX: 914-332-80
TTY: 866-933-48

www.opwdd.ny.g

August 2011

Dear Parent:

I have been asked to write a letter to parents to explain the need for social security numbers in registering your child for an OPWDD Family Support Services/Waiver funded program.

These programs are funded by New York State via Family Support Services (FSS) and Medicaid Waiver dollars through the state Office for People with Developmental Disabilities. (OPWDD). Hudson Valley DDSO in Tarrytown (see above address) is a branch office of OPWDD, and is responsible for monitoring all of these funded programs and making sure that all programs serve individuals with developmental disabilities who reside in Westchester county. All participants in the program must be registered with our office in order to demonstrate that the funds are being spent appropriately.

In order to avoid any confusion, social security numbers are required so that we make sure that we are registering the correct person. Once we have each individual registered, we can generate a roster of participants that lists the individuals served. We have to have a valid program roster to demonstrate to the auditors that the funding is being utilized appropriately.

If you are uncomfortable sharing the number in a public place, such as the program site, the agency will accommodate you in providing privacy to submit the number, either by telephone or at the agency office. Each agency now has a Secured Message Center (SMC) address to transmit information to OPWDD. You can ask the agency to transmit the number directly to me via their SMC address.

Thank you for your assistance with this matter.

Feel free to call me at 332-8958 if you have any questions on the above. You can also email me at Claudia.spaziante@opwdd.ny.gov.

Sincerely,

Claudia Spaziante, LMSW
Family Support Services
Hudson Valley DDSO

277 Martine Avenue, White Plains, New York 10601 (914) 358-5613

CLIENT APPLICATION FORM

To be completed by parent or legal guardian

PLEASE SUBMIT A COPY OF YOUR CHILD'S MOST RECENT IEP WITH THIS APPLICATION

Today's Date: ________________

General Information:

Child's Name: ____Date of Birth: _____________Age:_________

Child's Gender: ___M ___F Race/Ethnicity: _______________Child's Social Security # ________-_______-________

****

Father's name: _______________________________Street Address: _________________________________

City: _________________________ State: ________ Zip: _______________Home Phone: _______________

Cell Phone: _________________ Work Phone: _____________Email Address: _________________________

Occupation: ______________________ Place of Employment: ____________________________________

****

Mother's name: ______________________________Street Address: __________________________________

City: _________________________ State: ________ Zip: _______________Home Phone: _______________

Cell Phone: _________________ Work Phone: _____________Email Address: _________________________

Occupation: ______________________ Place of Employment: ____________________________________

Other children/siblings (and ages) or family members residing with you: ___________________________

____

Applying for following program(s):

____Saturday Creative Arts Therapy Program ____Weekday After School Program: (CIRCLE) M T W TH F

____ Specialty Programming/ Workshops

****

Medical Information

1) Please list any medical diagnoses that your child has: ____

____

2) Please list any psychiatric diagnoses that your child: ____

____

3) What is your child's special education classification? ____

4) Please list any of your child's known ALLERGIES: ____

____

5) Please List any medications that your child is taking: ____

____

Healthcare Insurance Information (please allow Heartsong to obtain a copy of your insurance card)

1) Insurance carrier: ____ Carrier's phone number: ________________
2) Policy or ID number: ______________________________________ Group #: ______________________________

Functional and Behavioral Skills

Daily Living Skills

1) My child is toilet trained: ___YES ___NO ___We are currently working on this skill
2) My child can dress themselves independently: ___YES ___NO ___We are currently working on this skill
3) My child can feed themselves independently: ___YES ___NO ___We are currently working on this skill

Gross and Fine Motor Skills

1) Are there any issues or concerns about your child's ability in the following areas:
   a. Walking/ Running: ____
   b. Posture/ Muscle Tone: ____
   c. Balance :____
2) Please describe your child's fine motor abilities: (grasping, writing, drawing) ____________________

   ____
3) Does your child receive any of the following services?

   ___Physical Therapy ____ times per week ___Occupational Therapy ____times per week

Sensory Integration

1) Please list any sensory issues or concerns:
   a. Visual (site) ____
   b. Auditory (sound) ____
   c. Tactile (touch) ____
   d. Other ____

Communication and Social Skills

1) My child's main way of communicating is:

   ____verbally, with full sentences _____slightly verbal using one or two words at a time

   ____ uses vocal sounds _____ signing and pointing with hands ____ augmentative device or visuals

Other ____

2) My child receives speech therapy: ____Yes ____times per week ____Not at this time

3) My child has and makes friends: ____easily ____has some difficulty ____cannot do this independently

4) My child has difficulty with the following:

____making eye contact with adults ____eye contact with peers ____transitioning

____recognizing facial expressions on others ____understanding and following directions

____ sharing toys or materials within a group or class other: ______________________________

Behavioral/ Emotional

1) Please describe your child's behavioral challenges:

____

____

2) What techniques and/or strategies do you use when your child gets upset? (Any sensory items or adaptive equipment needed?)

____

____

Other Services

1) My child receives the following therapies/ interventions:

____ABA (Applied Behavioral Analysis) ____Counseling or psychotherapy ____Academic tutoring

____Nutritional support (Gluten Free) ____ DIR Floortime ____RDI ____TEACH

____Sensory Integration Therapy other alternative therapies ______________________

2) Please list child's primary care Physician

Doctor's Name: ______________________________ Phone: ______________________

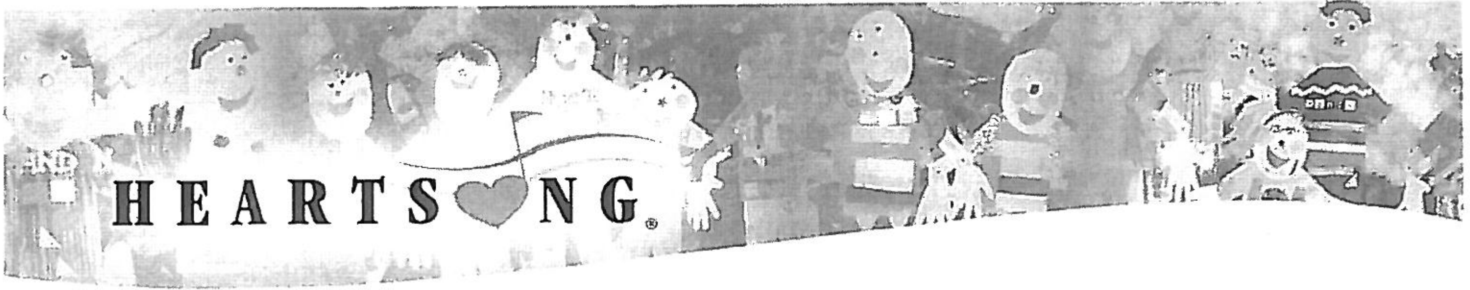
Doctor's Address: ____

****

By signing below, I am stating that all information above is correct to the best of my knowledge and that if anything should change I will notify Heartsong staff as soon as possible. I also acknowledge that my child's sessions may include the involvement of student interns and volunteers which assist trained staff. I am also aware and permit authorized visitors/observers to enter my child's sessions. While Heartsong staff work to ensure my child's safety, I also acknowledge and agree that my child's participation in the Heartsong program is at our own risk and I will not hold Heartsong, Inc. liable for injury not directly the result of Heartsong staff and program.

Parent's Signature: ____ Date: ____________

Parent's Name Printed: ____



Authorization for Release of Information

Child's Name: ______________________________ D.O.B. ____________

Your Name: ______________________________ Relation to Child: ____________

Address: ______________________________

______________________________ Phone: ______________________________

I hereby authorize ______________________________ (School/Agency) and Heartsong, Inc.

to release and mutually exchange written and verbal information from the record of

______________________________ for the purpose of evaluation and/or service provision.

The undersigned understands that any information released in accordance with this authorization may constitute privileged information. Accordingly, the undersigned waives said privilege and agrees to hold Heartsong, Inc. free and harmless from any liability in connection with the release of said information. The undersigned also understands that they may revoke this authorization at any time in writing to Heartsong, Inc.

Signature: ______________________________ Date: ______________

Name Printed: ______________________________

Witness Signature: ______________________________ Date: ______________

Witness Name Printed: ______________________________

Please return to: Heartsong, Inc. 277 Martine Avenue, Suite 230, White Plains, NY 10601
Ph: 914-420-9952 www.Heartsong.org

Revised 3/7/11

Physician's Authorization for Program Participation

This release is valid for up to three (3) years from the date of signature unless otherwise noted.

Patient Name:______________________________________Date of Birth:______________

1. Patient Diagnosis: ____

2. Does this patient have any physical disabilities related to:

	Disability	Extent
Ambulation	________________	____________________
Hearing	________________	____________________
Vision	________________	____________________
Speech	________________	____________________
Balance &Coordination	________________	____________________
Other (explain)	________________	____________________

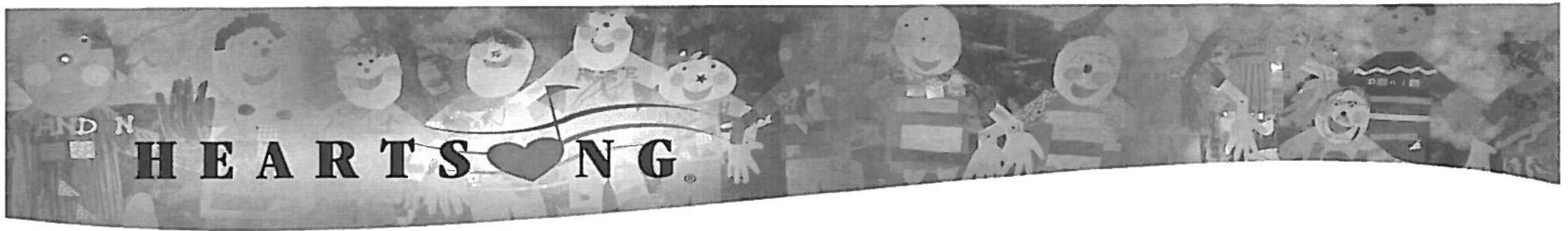
3. Patient History:
   a. Chronic diseases: Heart_______Diabetes______other ______________________________
      Describe: ____
   b. Seizures____________degree____________frequency_________________________
      Known Antecedent ____
   c. Colds____________________frequency________________
   d. Ear infections____________________frequency________________
   e. Allergies (food restrictions)_______________________________
   f. Hepatitis______________________________type:________________

4. Immunizations:
   a. Diphtheria/Tetanus Toxoid (4 doses) Dates:________,______,______,______
   b. Oral Polio Vaccine (3 or more doses) Dates: _______,_______,______,______
   c. Live Measles Vaccine (2 doses) Dates:___________ _______________
   d. Live Rubella Vaccine (2 doses) Dates:___________ _______________
   e. Live Mumps Vaccine (2 doses) Dates:___________ _______________
   If no, what immunizations are lacking: ______________________________

5. I recommend this patient for:
   a. ______full participation in the Heartsong program
   b. ______participation in the Heartsong program with the following imitations:_______________________________________
   c. ______no participation in any of Heartsong's programs due to:
   ____

6. Signature of Physician:____
   Physician Name (printed):____
   Physician Contact Information: ____________________________________
   Date: _______________________________________

Please return to: Heartsong, Inc. 277 Martine Avenue, Suite 230, White Plains, NY 10601
Ph: 914-420-9952 www.Heartsong.org Revised 4/15/11



Information Regarding Persons with Seizure Disorder

Child's Name: ___________________________________ **Today's Date:** ___________

Does your child have a **SEIZURE** disorder?	Yes		No	
➢ If no, please place a check above, draw a line through middle of form and sign below.				
➢ If yes, complete the rest of this form and provide doctor's instructions with your application				

Type of seizure: ____

Known causes: ____

Known triggers: ____

Date of last seizure:__________ Seizures per year:___________ Typical duration:______ min

During a seizure are there:

- o Unusual sensations (i.e., seeing colors, hearing sounds, strange taste or smell) before the seizure: ____
- o External signs a seizure is about to occur: ____ ____
- o Behaviors during the seizure: ____ ____
- o Memory loss/ Cognitive/ Other Changes:____

Doctor's name: ____

Doctor's phone number: ____

How should our staff to respond to a seizure while your child is at program?

Procedure:
- ______ Call 911 immediately
- ______ Call 911 if convulsions last more than________minutes
- ______ Call parents/guardian to report seizure immediately following seizure
- ______ Handle seizure by cushioning head and creating a safe surrounding
- ______ Other information we should know: ____________________________

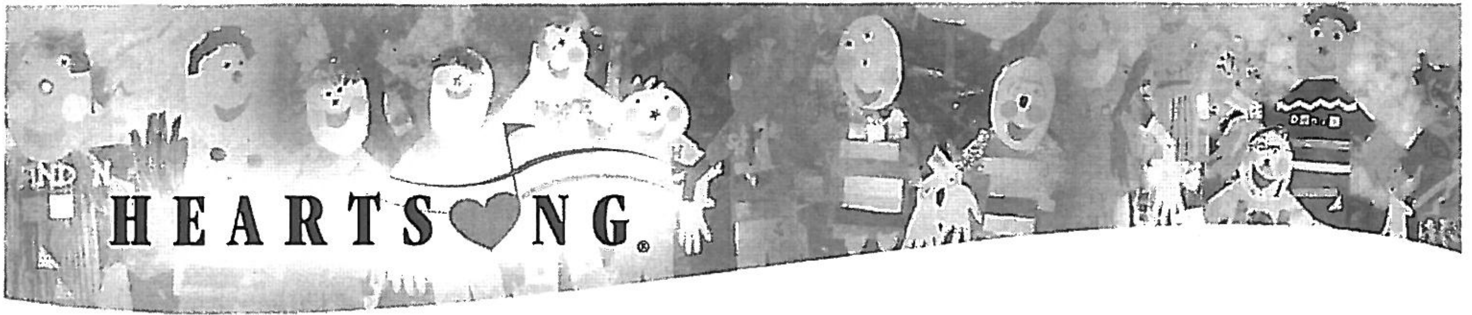
________________________ ________________________ ________

Parent/Guardian Signature Parent/Guardian Name Printed Date

________________________ ________________________ ________

Witness Signature Witness Name Printed Date

Please return to: Heartsong, Inc. 277 Martine Avenue, Suite 230, White Plains, NY 10601
Ph: 914-358-5613 Fax: 914-831-1051 www.Heartsong.org Revised 3/13/2014



Photography Consent Form for Minor Children

I (*print name*) ________________________________, parent or guardian of (*child's name*) ________________________________ hereby grant permission to Heartsong, Incorporated, its employees or representatives to take and use: photographs, videotape and/or digital images of my child for use in promotional or educational materials as follows: printed publications or materials, electronic publications or presentations, websites. I agree that my child's name and identity:

☐ May be revealed

☐ May not be revealed

in descriptive text or commentary in connection with the image(s). I authorize the use of these images indefinitely without compensation to me. All negatives, positives, prints, digital reproductions and videotape shall be the property of Heartsong, Incorporated.

____
(*Signature of Parent/Guardian*)

____
(*Signature of Witness*)

____
(*Parent/Guardian Name Printed*)

____
(*Witness Name Printed*)

____
(*Date*)

____
(*Date*)

Heartsong, Inc. 277 Martine Avenue, Suite 230 White Plains, NY 10601
Ph: 914-358-5613 Fax: 914-831-1051 www.Heartsong.org