

PARENT/GUARDIAN & EMERGENCY CONTACT INFORMATION

Parent/Guardian #1

Name: _____

Relationship to Student: _____

Address: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Custody: YES NO Guardianship: YES NO

Other/Agency

Name: _____

Address: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Custody: YES NO Guardianship: YES NO

Parent/Guardian #2

Name: _____

Relationship to Student: _____

Address: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Custody: YES NO Guardianship: YES NO

Other/Agency

Name: _____

Address: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Custody: YES NO Guardianship: YES NO

INSURANCE

Medical Assistance (MA): YES NO PENDING

MA# _____

EVS 410-333-3020 Checked: YES NO

Commercial Insurance Company: _____

Phone: _____

Billing Address: _____

Policy No: _____ Group # _____ Effective Date (MM/DD/YY): _____

Policyholder: _____ Policyholder Employer: _____

Relationship to Student/Patient: _____

Statement of (circle one) Benefits or Denial Recieved: YES NO Precertification Completed: YES NO

Copy of Insurance Card (Front & Back): YES NO

Authorization #: _____

Copy of MA Card (Front & Back): YES NO

Registered with HMO: YES NO

Eligible: YES NO Federal State

MCO: _____

Phone: _____

FOR OFFICE USE ONLY

School Enrollment Date (MM/DD/YY): _____

Program/Information Change Date (MM/DD/YY): _____ Date of Withdraw (MM/DD/YY): _____

Pupil # _____

Diagnosis: I _____ II _____

Treatment Team

Counselor: _____ Advisor: _____

Social Worker: _____ OT: _____

Speech Therapist: _____ 1:1 Assistant: _____

Med Consult: _____

Has the individual been in isolation or required any other spacial infection control precautions: YES NO

Is the individual proficient in English: YES NO

Diagnoses Code (ICDg): _____

Autism Waiver Approved: YES NO

Approval Letter Attached: YES NO

Care Plan Start/Expire Dates: Start (MM/DD/YY): _____ Expires (MM/DD/YY): _____

Federal Disability Code:

IEP Start/Expire Dates: Start (MM/DD/YY): _____ Expire (MM/DD/YY): _____ IEP LSS: _____

Educational Funding

Funding Source(s) for Edicational Services: _____

Contact Name: _____ Phone: _____

Address: _____

Verification Letter Attached: YES NO IEP Services Page Attached: YES NO

Cost Sheet Sent to Towson: YES NO

Grade Level: _____ Special Education Environment Code: _____

Division: _____ Intensity Level: _____