Florida Elks
CHILDREN'S THERAPY SERVICES
Mobile In-Home Therapy since 1999

Colleen C. Gallant, Director

Dear Prospective Patient:

Florida Elks Children's Therapy Services is a program that offers ***free*** in home therapy services to Florida children. These services are provided by a licensed Physical Therapist or licensed Occupational Therapist employed by the Florida Elks. These rehabilitative services are necessary to be rendered in the home because of the absence of these services locally, or because of the patient being medically infirmed at home.

Eligibility for treatment will be based on a number of factors including medical and other criteria; such as but not limited to:

- The patient must be a resident of Florida.
- The patient must be between the ages of birth and 18 years.
- The patient must have a condition necessitating Physical or Occupational therapies.
- The Patient must have rehabilitative potential
- The patient must have financial need for free services.

All questions on the application must be completed. Failure to do so will result in a delay in processing your application. If you have any questions, please don't hesitate to call on our toll-free number, 1-800-523-1673

Colleen Gallant, Director

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Post Office Box 49, Umatilla, Florida 32784-0049
352-801-6445 or 800-523-1673

Revised 02/2017

FLORIDA ELKS CHILDREN'S THERAPY SERVICES
POST OFFICE BOX 49
UMATILLA, FLORIDA 32784-0049
800-523-1673

Date:_____ **FECTS THERAPIST:**_____

PLEASE COMPLETE ALL BLANKS AND RETURN TO FLORIDA ELKS CHILDREN'S THERAPY SERVICES.

Patient's Name: _____ _____ _____ **Sex: Male / Female**

Birth Date: _____ **Age:** _____ **School Attending:** _____ **Grade:** _____

Who does child live with primarily? (Check One) Both Parents Mother Father Other

(Name)_____

MEDICAL INFORMATION

Patient's Medical Problem: _____

List any therapies patient is currently receiving: _____

Patient's Doctor: _____ **Date of last visit**: _____

Address of Doctor: _____

_____

Doctor's Phone Number:

WHO REFERRED YOU TO FLORIDA ELKS CHILDREN'S THERAPY SERVICES? _____

BIOLOGICAL INFORMATION

Name of Father: _____

Address: _____

Birthdate:_____ **Home Phone:** _____ **Cell Phone:** _____

Employer Name:_____

Employer Address: _____ **Phone:**_____

Name of Mother: _____

Address: _____ _____

Birthdate:_____ **Home Phone:** _____ **Cell Phone:** _____

Employer Name:_____

Employer Address:_____ **Phone:** _____

Email Address:_____

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Patient resides with:_____ **Phone**:_____ **Cell**:_____

Address:_____**E-Mail Address:**_____

Name of Legal Guardian:_____
(If different from above)

Documentation of Guardianship provided: _____

Relationship to child**:** _____

Address:_____

Birthdate: _____ Home #: _____ Work #: _____

E-Mail Address**:**_____ Cell Phone #: _____

FINANCIAL INFORMATION

Total Combined Family Income For Last 12 Months:

INSURANCE INFORMATION

Type:

Name of Company or Health Plan:_____

ID Number:_____

1. I certify that the above information is true and accurate to the best of my knowledge.
2. I understand that the information submitted is subject to verification by the Florida Elks Children's Therapy Services.

Parent/Guardian Signature:_____

Date:_____ Witness: _____

For FECTS Use Only: **RECOMMENDATIONS**

Accept _____ Reject _____

Reason for Rejection:

_____

Signature of Administrator Date

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ADDITIONAL PATIENT COMMENTS

THERAPIST NOTES

Name of Therapist Reviewing Application: _____

Date Reviewed: _____

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