Phone: 502.550.2525
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PARTNERS IN COMMUNICATION, INC

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INQUIRY / SERVICE REQUEST FORM

Please complete the following to request a service through PIC. If a service provider is not immediately available, you will be placed on a waiting list for your area. You will be contacted when a service provider is available to meet your needs.

Date:	**CLIENT Name :**
CLIENT Address: Street	**CASE MANAGER / CONTACT Name:**
City , State, Zip:	**CASE MANAGER / CONTACT Phone Number:**
CLIENT Age:	**CASE MANAGER / CONTACT Email Address:**
CLIENT Diagnoses (if any):	**CASE MANAGER / CONTACT Agency:**
CLIENT Living Arrangements: ☐Alone ☐With Spouse ☐Other_____ ☐Parents ☐Group Home	**PARENT / CAREGIVER Name:**
Service(s) interested in: **THERAPY:** ☐ Speech-Language Pathology (SCL & ABI) ☐ Occupational Therapy (SCL & ABI) ☐ Physical Therapy (SCL) **SUPPORT SERVICES:** ☐ Supported Employment (SCL & ABI) ☐ Community Living Supports (SCL) ☐ Respite (SCL & ABI) ☐ Adult Day Training (SCL) ☐ Structured Day Program Services (ABI) ☐ Children's Day Habilitation (SCL) ☐ Companion Services (ABI) ☐ Personal Care Services (ABI) ☐ Specialized Medical Equipment & Supplies (ABI)	**PARENT / CAREGIVER Phone Number &/or E-mail Address:** **Is Client CURRENTLY receiving Waiver services or desiring to use Insurance funds?** ☐ No ☐Yes: ☐ SCL ☐ Medicare ☐ ABI ☐ Private Insurance ☐ Michelle P. ☐ Other:_____ **If client is NOT eligible for therapies through insurances or waiver programs, does client / caregiver agree to self-pay (pay out-of-pocket) for services?** ☐ Yes ☐ No **DAYS & TIMES Client is AVAILABLE (Be Specific):** **How did you hear about PIC?**
NOTES / COMENTS / REQUESTS :	
Staff person completing &/or reviewing form:	