CHILDREN'S THERAPY CENTER

Celebrate what is. Commit to what can be.

Directions to

Children's Therapy Center
8717 S. Hosmer St.
Tacoma, WA 98444
Phone 253.531.8873

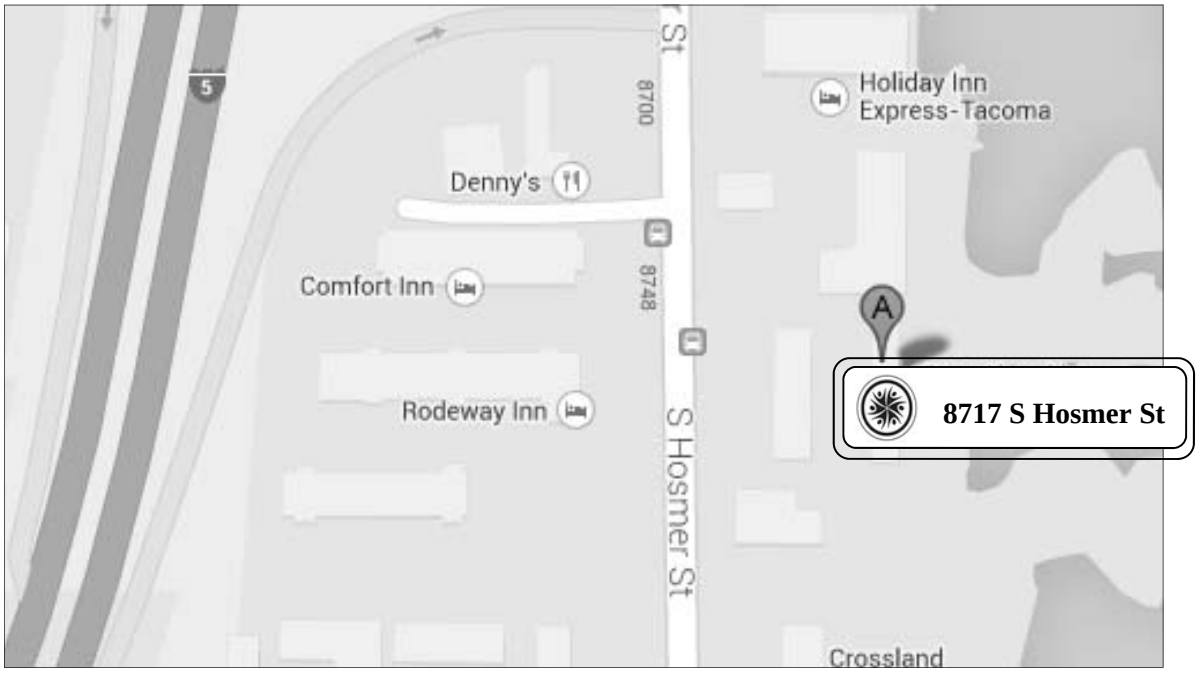
South Bound I-5

⇒ Take EXIT 129 toward SO. 84 ST.
⇒ Turn LEFT onto TACOMA MALL BLVD S.
⇒ Turn LEFT onto 84TH ST S.
⇒ Turn RIGHT onto S HOSMER ST.
⇒ End at 8717 S Hosmer St Tacoma, WA 98444

North Bound I-5

⇒ Take EXIT 128 toward SO 84 ST.
⇒ Turn RIGHT onto S HOSMER ST.
⇒ End at 8717 S Hosmer St Tacoma, WA 98444

CTC is located behind the Handi Deli & Mart



CHILDREN'S THERAPY CENTER
Celebrate what is. Commit to what can be.

Phone: 253-854-5660
Fax: 253-854-7025
www.ctckids.org

Kent
10811 SE Kent-Kangley Rd.
Kent WA 98030

Burien
127 SW 156th St.
Burien, WA 98166

Tacoma
8717 S Hosmer St.
Tacoma, WA 98444

RELEASE OF INFORMATION

I, **(Parent/Guardian)**_____, hereby grant consent for Children's Therapy Center to give and/or receive information pertaining to the Physical/Occupational/Communication/Oral Motor Therapy, Prosthetic/Orthotic programs and/or Education programs for (**Child's Name**) _____ **(other names known by)** _____ (**Child's Date of Birth)**_____ with the professionals or agencies listed below for the purpose of coordination of care. Records released may include all information concerning any testing, diagnosis or treatment related to HIV, STD, psychiatric and/or drug/alcohol. A photocopy of this document shall be considered to be as valid as the original.

Please list names of people who help you with your child, including primary physician, public health nurse, therapists, specialists, day care staff, and other agencies:

Contact Person's Name	Agency/Clinic Name and Address	Phone #
Doctor (Primary):		
Doctor (Other):		
Hospital:		
Public Health Nurse:		
School District:		
Caseworker:		
Physical/Occupational/Speech Therapist:		
Other:		

Rights: I understand I do not have to sign this release in order for the patient to receive services (treatment, evaluation, or enrollment). However, I do have to sign a release form in order for the organization to share information regarding the patient on my behalf. I understand that any disclosure of information carries with it the potential for further release or distribution by the recipient that may not be protected by confidentiality laws.

_____ _____ _____

Signature of Parent or Legal Guardian **Relationship to Child** **Date**

Expiration: This release will be valid for the patient's duration of participation in our programs and will expire one year after the patient's discharge. This release may be revoked at any time by the above signed through submission of a written and signed statement. Revoking this release of information will not impact information released prior to the date of the written revoke request.

Client Demographic Form July 2018 - June 2019

As a nonprofit agency, Children's Therapy Center receives funding from United Way. We share with United Way demographic information for participants in our programs. We do not include your name so that your identity is kept completely confidential. Please take a few moments to complete this form. Thank you!

United Way
King and Pierce County

Mark an **X** in the box(es) for each question.

1. Household Composition

Please check one:

- ☐ Two parent household
- ☐ Single parent (male)
- ☐ Single parent (female)
- ☐ Other related household

2. Total Gross Household Income

Please check one *based on the chart below**:

- ☐ Under 30% of Median Income (A)
- ☐ Under 50% of Median Income (B)
- ☐ Under 80% of Median Income (C)
- ☐ Equal or Above 80% of Median Income (D)

3. Are you currently homeless? (check one)

- ☐ YES ☐ NO

Thank you for your reply.
Your information will
be kept completely confidential.

4. Ethnicity:

Child is Spanish / Hispanic / Latino

- ☐ YES ☐ NO

5. Child's Race: (check all that apply)

- ☐ American Indian or Alaska Native
- ☐ Asian, Asian American
- ☐ Black, African American, Other African
- ☐ Native Hawaiian or Pacific Islander
- ☐ White or Caucasian
- ☐ Other

6. Limited English Proficiency

Are you (parent/adult) limited in your ability to communicate in English? (check one)

- ☐ YES ☐ NO

7. Active Military

Are you (parent/adult) active military? (check one)

- ☐ YES ☐ NO

***Instructions:** Under FAMILY SIZE, choose the row for the number of people in your household. Select the income range in that row for your ANNUAL GROSS INCOME for last year. The letter A, B, C or D above that column will be your income category for question #2.

King County – HUD Income Guidelines 2018

	PERCENT OF MEDIAN INCOME			
	30% HUD PMSA	50% HUD PMSA	80% HUD PMSA	Over 80% HUD PMSA
FAMILY SIZE ↓↓↓	Very Low A	Low B	Moderate C	Above Moderate D
1 Person	Up to $ 22,500	$ 22,501 to $ 37,450	$ 37,451 to $ 56,200	$ 56,201 or more
2 People	Up to $ 25,700	$ 25,701 to $ 42,800	$ 42,801 to $ 64,200	$ 64,201 or more
3 People	Up to $ 28,900	$ 28,901 to $ 48,150	$ 48,151 to $72,250	$ 72,251 or more
4 People	Up to $ 32,100	$ 32,101 to $ 53,500	$ 53,501 to $ 80,250	$ 80,251 or more
5 People	Up to $ 34,700	$ 34,701 to $ 57,800	$ 57,801 to $ 86,700	$ 86,701 or more
6 People	Up to $ 37,250	$ 37,251 to $ 62,100	$ 62,101 to $ 93,100	$ 93,101 or more
7 People	Up to $ 39,850	$ 39,851 to $ 66,350	$ 66,351 to $ 99,550	$ 99,551 or more
8 People	Up to $ 42,400	$ 42,401 to $ 70,650	$70,651 to $105,950	$ 105,951 or more

FY 2017, Median Income for Family of 4 People = $96,000

HUD (U.S. Department of Housing and Urban Development) PMSA (Primary Metropolitan Statistical Areas) Rev 7/18

Children with Special Health Care Needs
CHILD HEALTH INTAKE FORM

☐ Case Management ☐ CSHCN Eligible				☐ New ☐ Renewal
CHILD'S NAME (LAST, FIRST, MI)	2. DOB	3. SSN	4. SEX	5. RACE/ETHNIC PREFERENCE
6. FATHER/GUARDIAN/FOSTER PARENT NAME	7. DOB	8. SSN	9. FAMILY SIZE	LANGUAGE 10. 11.12.13.
14. MOTHER/GUARDIAN/FOSTER PARENT NAME	15. DOB	16. SSN	16A. MOM'S EDUCATION LEVEL	17. REFERRED BY
19. ADDRESS CITY STATE ZIP	20. PHONE (Home)	21.PHONE (Work)	22. PHONE (Message)	18. INCOME: UNDER / OVER 200% FPL

24. OTHER DEPENDENTS IN HOUSEHOLD	25. RELATIONSHIP	26. DOB	27. PRIMARY PHYSICIAN/ADDRESS/PHONE
			28. DIAGNOSIS/MEDICAL PROBLEMS/ICD-9
			29. ICD-9-CODE(S)

30. NOTES / COMMENTS	30(A).	31. CHIF DATE
	33. MEDICAL HISTORY	

32. REASON FOR REFERRAL	35. HEALTH/MEDICAL INSURANCE
	☐ INSURARANCE Name: _____ Group #: _____
	☐ INSURARANCE Name: _____ Group #: _____
34. OTHER HEALTH CARE SPECIALISTS/PROVIDERS	☐ CHAMPUS/TRICARE: _____ _____ Group #: _____
	☐ MEDICAL COUPONS: _____ PIC # / CASE #: _____ _____ _____
	☐ OTHER: _____ _ _____

36. AGENCY INVOLVEMENT: (Please check all that apply)

☐ WIC ☐ SSI ☐ SSS ☐ DDD ☐ FOSTER CARE ☐ SCHOOL/IEP/IFSP_____ ☐ GS-CTU ☐ MB-NDP

☒ CHILDREN'S THERAPY CENTER-TACOMA ☐ _____ ☐ _____ ☐ BIRTH TO THREE DEV CTR FW

AGENCY SUBMITTING THIS CHIF: CHILDREN'S THERAPY CENTER – TACOMA

DO NOT WRITE IN SHADED AREAS

Submitting Agency: Please return this completed form to: Children w/Special Health Care Needs Program in Client's County