1537 Heritage Boulevard
West Salem, WI 54669
608-799-4860
414-377-3353
hello@lihmt.com
lihmt.com

Request for Services

NOTE: If you are completing this form on behalf of someone else, please respond from the perspective of the individual.

Client Information

Our first step is to collect identifying information and contact details.

Legal First & Last Name: _____ Preferred Name: _____ Birthdate: _____ Age Group: ○ Youth ○ Adult (18+)

Gender Information: _____ Pronouns: _____

Primary Contact Information:

Street Address of Primary Residence: _____ Apt./Unit #: _____ City: _____ State: _____ Zip Code: _____

Name & Relationship of Caregiver(s)/Guardian(s) at this Residence (if applicable): _____

Primary Phone #: _____ OK to leave message? ○ Yes ○ No

Primary Email: _____ How do you wish to complete paperwork? ○ Electronically (requires email) ○ On paper

Additional Contact Information:

If applicable, list any additional authorized individuals who may sign on your behalf. Portions of the intake paperwork will be sent to this address.

Street Address of Additional Residence (Street, Apt./Unit, City, State, Zip Code): _____

Name & Relationship of Caregiver(s)/Guardian(s) at this Residence (if applicable): _____

Additional Contact Phone #: _____ OK to leave message? ○ Yes ○ No

Additional Contact Email: _____ How do you wish to complete paperwork? ○ Electronically (requires email) ○ On paper

Additional Information: _____

Reason for Referral

Our next step is to learn about how we may assist you. Share an overview of the primary reason for which you are seeking music therapy services. If service authorization is required, please attach the current service plan and any supportive documents to best understand the needs and abilities.

Briefly describe the presenting need(s), functional skill(s), or outcomes you wish to prioritize:

List any diagnoses or disabilities pertaining to this need (if applicable):

Service Coordination

Our third step is to collect information to help us coordinate your services. We strive to provide a service that allows you to attend regularly and fits within your week. Due to high demand, please note that service availability in our outreach locations or after 3:00 PM may be limited. When identifying your requested service location, please review the following information:

- If virtual, you will attend from a separate remote location, using an electronic device with access to a stable Internet connection.
- If in-person, you will attend at an LIH facility/location, using COVID-19 precautions such as social distancing, physical barriers, masks, etc.

Scheduling

Delivery Method(s) of Interest:
☐ Attend In-Person ☐ Attend Online

Service Setting:
☐ Individual ☐ Sibling Group ☐ Small-Group (if available) ☐ Other

Service Location(s) of Interest:
☐ A confidential remote location ☐ West Salem Main Facility ☐ Tomah Outreach Facility ☐ Viroqua Outreach Facility
☐ Black River Falls Outreach Location

General Availability (Select all that apply):
○ Weekday - Morning ○ Weekday - Afternoon ○ Weekday - After 3:00 PM ○ Saturday - Before 1:30 PM
○ Flexible - Please assign me the next available time.

Is there anything else you'd like our team to know about your current scheduling needs?

Referring Person or Program

Person Completing Form: Title/Role or Relationship: Agency (if applicable):

Program or Payer Source (*requires referral service authorization from service coordinator):
○ Children's Long-Term Support Waiver* ○ Children's Community Options Program* ○ Comprehensive Community Services*
○ Family Care* ○ IRIS or Other Fiscal Agent* ○ Grant Funds* ○ MN State or Medicaid Program* ○ Self-Pay ○ Other

How can our team connect back with you to receive additional information or provide a status update?

Questions or Additional Information