

REQUEST FOR AN ASSESSMENT

Print and complete this form and mail it to The Joy of Music, LLC 305 W Main St Ste D Washington, IA 52353. We will address each application as quickly as possible. Questions? Call (319) 653-4445 or (319) 461-7410. Thank you for your interest.

Basic information

Client name: _____ DOB: _____ Age: _____
Address: _____ Phone: _____
_____ Diagnosis: _____
Contact Person: _____ Relationship: _____
Address: _____ Phone: _____
_____ Alt Phone: _____
Email: _____

Client lives: ___ with Parent/Guardian ___ at Facility ___ Other _____
Facility name: _____ Phone: _____
(if applicable)
Address: _____ Alt Phone: _____
_____ Email: _____
Contact Person: _____

Financial information Client has ___ Waiver _____
___ Consumer Choice Option (CCO)
Payee ___ Private (including SSI)
___ CCO

Who shall we bill for the services?

Name: _____
Address: _____
Phone: _____ Email: _____

Others who are involved with client (teachers, case workers, etc): _____

Please explain why this person is being referred to music therapy: _____

Is there anything else you would like us to know about this person? _____

Referral for services made by: _____

How did you hear about us? _____