

THTR FALL 2022: Returning Participant

Name: _____ Age: _____

Weight: _____ Height: _____

Legally Responsible Party for Rider and Billing:

Name: _____ Cell Phone: _____

Relationship to Rider: _____ Email: _____

Mailing Address: _____

Texts ok? ___YES ___NO

THIS Section: Individuals paying with Medicaid

Case Worker Name: _____

Case Worker Phone: _____ Email _____

I give THTR and/or Back Office Solutions permission to contact this case worker for billing purposes _____ (Initials of Rider or Legally Responsible Party)

**Note: THTR is covered under Montana Medicaid Community & Home Based Services. In order for our services to be covered by Medicaid, clients are required to be enrolled in a participating Medicaid Waiver program and have a case worker with the ability to provide a Prior Authorization Referral for services. ANY and ALL charges not covered by Medicaid will be billed and due by the client or guardian.*

EMERGENCY CONTACT INFORMATION – REQUIRED for ALL

Please furnish the name and phone # of a contact person (if under 18, in addition to parent)

Name: _____ Relationship to Rider _____

Address: _____

Home Phone: _____ Cell: _____ Work: _____

Physician Name: _____ Phone: _____

If any of the following has changed since we last saw you, please provide THTR with updated version: Current Medication List * Allergies * IEP * Physical Restrictions

What are participant's goals for this session? _____

Availability: This Fall we will be offering Two 6-Week Sessions. List ALL availability

Session 1: Sept 6 – Oct 17 Session 2: Oct 24– Dec 9

Note: No lessons Session 2 the week of Thanksgiving

Day	Mondays	Tuesdays	Wednesdays	Thursdays	Fridays
Times available:					

Top Choice (we'll do our best!) _____