



2075 MAX LUTHER DRIVE, HUNTSVILLE, AL 35810  
PHONE: (256) 852-5600 • FAX (256) 852-6722

**Thank you for giving us the opportunity to provide services to your family!** Here is a breakdown of the documents contained in this envelope:

1. Acknowledgement of Receipt of Patient Privacy Notice (Pink)-this is our acknowledgement that you have received the packet explaining the ways we protect your PHI (personal health information). **Please sign and bring to your child's 1<sup>st</sup> appointment.**
2. Patient Privacy Notice-the packet mentioned above. **This is yours to keep.**
3. Outpatient Application/Intake Form (5 pages)-Please fill this out completely to the best of your knowledge, and be sure to **sign** all signature lines **with a black "X" to the left**, even if there is no applicable information. On the Records Release Authorization page, at a minimum, please write your child's pediatrician on this form..
4. Therapy Charge Listing-this is a listing of our charges for services. Your insurance may cover your visits in total or in part, but these are the charges for each visit. Some insurances have deductibles to meet on a yearly basis. If you have any specific questions, we pull your insurance eligibility as a courtesy, and you can call Kim McCain at 852-5600 ext. 112 with any insurance questions. Our office accepts either checks or cash.
5. UCP Services Brochure- this brochure lists all of the additional services we offer, and is yours to keep.

Thank you again for allowing us the opportunity to work with your family. If you have any questions, please do not hesitate to call me at (256) 852-5600 ext 100.

Schara Davis-Spratlen  
Outpatient Coordinator  
UCP of AL and TN Valley  
mpalat@ucphuntsville.org

# Outpatient Application / Intake Form



Today's Date \_\_\_\_\_

Client's Name \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_  
Street address

\_\_\_\_\_

City State Zip

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

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E-mail address (please print legibly!) \_\_\_\_\_

Client's Date Of Birth \_\_\_\_\_ Male \_\_\_ Female \_\_\_ Client's Social Security Number \_\_\_\_\_

Diagnosis \_\_\_\_\_

Father's Name (if client is a minor) \_\_\_\_\_ Father's Age \_\_\_\_\_

Place of Employment \_\_\_\_\_ Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_

Mother's Name (if client is a minor) \_\_\_\_\_ Mother's Age \_\_\_\_\_

Place of Employment \_\_\_\_\_ Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_

Client Resides With \_\_\_\_\_

Emergency Contact \_\_\_\_\_  
Name Phone Relationship to Client

Client's Physician \_\_\_\_\_

Please list other agencies, clinics, hospitals, etc. who have served client for therapy, evaluation, consultation, or treatment (ex: Children's Rehabilitation Services, Vocational Rehabilitation, etc.): \_\_\_\_\_

Is the client coming in as the result of an accident or injury?  Yes  No **If yes, please answer questions below:**

Date of accident: \_\_\_\_\_ Type of accident (car, 3-wheeler, etc.): \_\_\_\_\_

State that accident occurred in: \_\_\_\_\_

Were there any prenatal and/or birth problems? If so, please list them below.

Please list date(s) and reason(s) for all hospitalizations and/or surgeries.

Please list the members of household and their relationship to the client.

I hereby give permission for the evaluation and assessment of above client to be performed by qualified professionals as indicated. I hereby authorize UCP to file insurance and receive payment for services rendered. I am financially responsible for deductibles and other charges accrued that insurance does not cover, at time of service, for above-mentioned client.

**X** \_\_\_\_\_  
Client / Parent / Guardian Signature Date

Does this client have a long-term disability? Yes \_\_\_\_\_ No \_\_\_\_\_  
If so, you may qualify for financial assistance to cover co-pays, deductibles and/or other accrued charges.  
Would you like to find out more information regarding financial assistance? Yes \_\_\_\_\_ No \_\_\_\_\_

Primary Insurance \_\_\_\_\_ Policy Holder \_\_\_\_\_  
Policy Holder's Date of Birth: \_\_\_\_\_ Policy Number \_\_\_\_\_ Group # \_\_\_\_\_  
Policy Holder's Address: \_\_\_\_\_  
Address of Insurance Company \_\_\_\_\_  
Street Address/P.O. Box \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ Policy Holder \_\_\_\_\_  
Policy Holder's Date of Birth: \_\_\_\_\_ Policy Number \_\_\_\_\_ Group # \_\_\_\_\_  
Policy Holder's Address: \_\_\_\_\_  
Address of Insurance Company \_\_\_\_\_  
Street Address/P.O. Box \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Tertiary Insurance \_\_\_\_\_ Policy Holder \_\_\_\_\_  
Policy Holder's Date of Birth: \_\_\_\_\_ Policy Number \_\_\_\_\_ Group # \_\_\_\_\_  
Policy Holder's Address: \_\_\_\_\_  
Address of Insurance Company \_\_\_\_\_  
Street Address/P.O. Box \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

I hereby authorize United Cerebral Palsy to release any and all information concerning evaluation, assessment or services to the above insurance companies. I understand that I am financially responsible for charges not covered by insurance. By my signature below, I authorize payment of medical benefits to United Cerebral Palsy for therapy services rendered.

**X** \_\_\_\_\_  
Client / Parent / Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

### Client's Emergency Medical Treatment Authorization

Other specialists involved in client's care (please include phone numbers) \_\_\_\_\_

List any known allergies \_\_\_\_\_

Date of last tetanus antitoxin \_\_\_\_\_ Booster \_\_\_\_\_

Contagious diseases, major illnesses, accidents or surgery \_\_\_\_\_

Please list pertinent information \_\_\_\_\_

Please list current medication(s) and dosage \_\_\_\_\_

I hereby give permission for provisions of emergency medical treatment for the above-named client as follows:

1. Staff members of United Cerebral Palsy and Tennessee Valley may arrange for transporting the above-named client to the emergency room by calling 911 and following emergency procedures as outlined by 911 personnel.
2. Records pertinent to emergency treatment may be released to hospital personnel.
3. Physicians and hospital personnel have permission to provide emergency medical treatment to the above-named client.

**X** \_\_\_\_\_  
Client / Parent / Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

The following people are hereby authorized to escort my child to and from the UCP Center (i.e. grandparents, other relatives, nanny, etc.):

Name	Relationship to child
_____	_____
_____	_____
_____	_____
_____	_____

The following people are hereby authorized to receive treatment information about my child from the staff of the UCP Center. Please consider listing the people who are authorized to bring your child to the UCP Center above (i.e. grandparents, other relatives, nanny, etc.):

Name	Relationship to child
_____	_____
_____	_____
_____	_____
_____	_____



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## Records Release Authorization

Client's Name: \_\_\_\_\_  
                   First                                    Middle                                    Last

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Address: \_\_\_\_\_  
             Street Address

\_\_\_\_\_  
 City, State and Zip

I give my permission to United Cerebral Palsy of Huntsville and Tennessee Valley, Inc., (UCP) to release **and/or** receive information from any individual or agency listed below about the above client's evaluation, assessment or treatment through UCP. I know my permission is voluntary and can be revoked at any time in writing. Copies of this release form will be considered as an original. This signed release form will be effective for one year from date of signature below.

The individual(s) or agency(ies) that are allowed to release/receive information:

- |    |       |       |
|----|-------|-------|
| 1. | _____ | _____ |
|    | Name  | Phone |
| 2. | _____ | _____ |
|    | Name  | Phone |
| 3. | _____ | _____ |
|    | Name  | Phone |
| 4. | _____ | _____ |
|    | Name  | Phone |
| 5. | _____ | _____ |
|    | Name  | Phone |
| 6. | _____ | _____ |
|    | Name  | Phone |
| 7. | _____ | _____ |
|    | Name  | Phone |
| 8. | _____ | _____ |
|    | Name  | Phone |

Client/Parent/Guardian Signature: **X** \_\_\_\_\_ Date: \_\_\_\_\_

## OUTPATIENT POLICY

United Cerebral Palsy Center of Huntsville and Tennessee Valley (UCP) Outpatient Program requires compliance with the following statements.

1. I agree to the evaluation and ongoing assessment of myself or my minor child in the areas of physical and/or speech and language development with the understanding that such evaluation and assessment will be conducted by personnel trained to utilize appropriate methods and procedures and will be based on informed clinical opinion and/or formal testing.
2. Prescriptions, EPSDT, and other medically necessary information must be submitted prior to enrollment into the program. I agree to assist the UCP staff in annually updating medical referrals and health status as needed. I further agree to request pertinent records as specifically authorized by my signature on appropriate release forms.
3. Parent / caregiver participation is encouraged and will be required. Homework will be assigned to the client and it will be the responsibility of the parent / caregiver to assist with that effort.
4. **Emergency Care:** The United Cerebral Palsy Center has my permission to obtain emergency care at the client's / parent's / caregiver's expense in the event of sickness or accident. The UCP Center staff will attempt to reach the parent / caregiver and / or physician first. I give permission for the client to be transported to the doctor's office or local hospital by ambulance or private car at the expense of my family. The Center's nurse will determine need for emergency care. I release the United Cerebral Palsy Center and it's staff of all responsibility for any accident that might occur during participation in a program or during transportation to or from the Center or other Center Activities.
5. **Attendance: I agree to call the Center as early as possible or no later than 8:00 AM of the scheduled appointment day if I need to cancel my appointment.** UCP requires a 24-hour cancellation notice to prevent a cancellation fee. I understand that if I do not comply with this policy, I may be charged a \$10.00 cancellation fee. In the event of two absences from regular appointments, I understand that client will lose their regular appointments and will be given one appointment at a time.
6. I understand that siblings are welcome in the Center and that the caregiver is responsible for their care. **Siblings are not allowed in the therapy or work areas of the Center.**
7. I understand that the client is responsible for paying any deductible and / or copays on their insurance coverage. Any payment plan set up with UCP is due upon receipt of services. All questions and concerns about insurance, Medicaid or personal pay plans should be addressed to our insurance billing personnel.
8. I understand that I am responsible for any equipment loaned to my minor child or myself. If equipment is not returned within 6 months from date of loan, I will be directly responsible for any costs incurred to replace the item.

X

\_\_\_\_\_  
Client / Parent / Guardian Signature

\_\_\_\_\_  
Date



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## PATIENT PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

**PLEASE REVIEW IT CAREFULLY**

### **USE AND DISCLOSURE OF HEALTH INFORMATION**

United Cerebral Palsy of Huntsville and Tennessee Valley, Inc. (UCP) may use your health information for purposes of providing you treatment, obtaining payment for your care and conducting health care operations. UCP has established a policy to guard against unnecessary disclosure of your health information.

THE FOLLOWING IS A SUMMARY OF THE CIRCUMSTANCES UNDER WHICH AND PURPOSES FOR WHICH YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED.

**To Provide Treatment:** UCP may use your health information to coordinate care within UCP and with others involved in your care, such as your attending physician.

**To Obtain Payment:** UCP may include your health information in documentation used to collect payment from third parties for the care you may receive from UCP. For example, UCP may be required by your health insurer to provide information regarding your health care status so that your insurer will pay benefits for treatment received. UCP may also need to obtain prior approval from your insurer and may need to explain to the insurer your need for treatment and the services we will provide to you.

**To Conduct Health Care Operations:** UCP may use and disclose health care information in order to facilitate the management of UCP. Health care operations include such activities as:

- Quality assessment and improvement activities
- Activities designed to improve health care or reduce health care costs
- Professional review and performance evaluation
- Training programs including those in which students, trainees or practitioners in health care learn under supervision
- Accreditation, certification, licensing or credentialing activities
- Review and auditing, including compliance reviews, medical reviews, legal services and compliance programs
- Business planning and development including cost management, establishing fees for services, and planning related analyses
- Business management and general administrative activities of UCP

For example, UCP may use your health information to evaluate its staff's performance, combine your health information with other UCP patients in evaluating how to more effectively serve all UCP patients, disclose your health information to UCP staff and contracted personnel for training purposes, use your health information to contact you as a reminder regarding an appointment.

**When Legally Required.** UCP will disclose your health information when it is required to do so by any Federal, State or local law.

**When There are Risks to Public Health.** UCP may disclose your health information for public activities and purposes in order to:

- Prevent or control disease, injury or disability, report disease, injury, vital events such as birth or death and the conduct of public health surveillance, investigations and interventions.
- Report adverse events, product defects, to track products or enable product recalls, repairs and replacements and to conduct post-marketing surveillance and compliance with requirements of the Food and Drug Administration.
- Notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease.
- Notify an employer about an individual who is a member of the workforce as legally required.

**To Report Abuse, Neglect or Domestic Violence.** UCP is required by law to notify government authorities if UCP believes a patient is the victim of abuse, neglect or domestic violence. UCP will make this disclosure only when specifically required or authorized by law or when the patient agrees to the disclosure.

**To Conduct Health Oversight Activities.** UCP may disclose your health information to a health oversight agency for activities including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action.

**In Connection with Judicial and Administrative Proceedings.** UCP may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process. UCP will make reasonable effort to notify you about the request.

**For Law Enforcement Purposes.** UCP may disclose your health information to a law enforcement official for law enforcement purposes as follows:

- As required by law for reporting of certain types of wounds or other physical injuries pursuant to the court order, warrant, subpoena, summons or similar process.
- For the purpose of identifying or locating a suspect, fugitive, material witness or missing person.
- Under certain limited circumstances, when you are the victim of a crime.
- To a law enforcement official if UCP has a suspicion that your death was the result of criminal conduct
- In an emergency in order to report a crime.

**In the Event of a Serious Threat to Health or Safety.** UCP may, consistent with applicable laws and ethical standards of conduct, disclose your health information if UCP, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

**For Specified Government Functions.** In certain circumstances, the Federal regulations authorize UCP to use or disclose your health information to facilitate specified government functions relating to military and veterans, national security and intelligence activities, protective services for the President and others, and medical suitability determinations.

**For Worker's Compensation.** UCP may release your health information for worker's compensation or similar programs.

## **AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION**

Other than stated above, UCP will not disclose your health information other than with your written authorization. If you or your representative authorizes UCP to use or disclose your health information, you may revoke that authorization in writing at any time.

## **YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION**

You have the following rights regarding your health information that UCP maintains and you may ask for any of the following in writing to the HIPAA OFFICER. Requests will be processed within 10 business days from the date of the request:

- **Right to Request Restrictions.** You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on UCP's disclosure of your health information to someone who is involved in your care or the payment of your care. However, UCP is not required to approve your request.
- **Right to Receive Confidential Communications.** You have the right to request that UCP communicate with you in a certain way. For example, you may ask that UCP only conduct communications pertaining to your health information with you privately with no other family members present. UCP will not request that you provide any reasons for your request and will attempt to honor your reasonable requests for confidential communications.
- **Right to Inspect and Copy Your Health Information.** You have the right to inspect and copy your health information, including billing records. If you request a copy of your health information, UCP may charge a reasonable fee for copying and assembling costs associated with your request.
- **Right to Amend Health Care Information.** If you or your representative believes that your health information records are incorrect or incomplete, you may request that UCP amend your records. That request may be made as long as the information is maintained by UCP. UCP may deny the request if it is not in writing or does not include a reason for the amendment. The request also may be denied if your health information records were not created by UCP, if the records you are requesting are not part of UCP's records or if, in the opinion of UCP, the records containing your health information are accurate and complete.
- **Right to an Accounting of Disclosures.** You or your representative have the right to request an accounting of disclosures of your health information made by UCP for any reason other than for treatment, payment or health operations. The request should specify the time period for the accounting starting on or after April 14, 2003. Accounting requests may not be made for periods of time in excess of six years. UCP will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. Requests for accounting of disclosures will be handled within 3 business days of receipt.
- **Right to a Paper Copy of This Notice.** You or your representative has a right to a separate paper copy of this Notice at any time even if you or your representative has received this Notice previously. A copy will also be posted at the center. Subsequent copies are available at no charge electronically via email.

**COMPLAINTS AGAINST UNITED CEREBRAL PALSY OF HUNTSVILLE AND TENNESSEE VALLEY, INC.**

**Right to File a Complaint Against UCP Without Fear of Retaliation.** You or your representative has a right to file a complaint against UCP regarding the handling of protected health information. Complaints should be filed in writing with UCP's HIPAA Compliance Officer or with the DHHS secretary if not resolved directly with UCP.

**DUTIES OF UCP**

UCP is required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of its duties and privacy practices. UCP is required to abide by terms of this Notice as may be amended from time to time. UCP reserves the right to change the terms of its Notice and to make the new Notice provisions effective for all health information that it maintains. If UCP changes its Notice, UCP will provide a notice of amended language to you or your appointed representative. A copy of the revised Notice is also available upon request. You or your personal representative has the right to express complaints to UCP and to the Secretary of Health and Human Services if you or your representative believes that your privacy rights have been violated. Any complaints to UCP should be made in writing to UCP's HIPAA Compliance Officer. UCP encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

**CONTACT PERSON**

UCP's contact person for all issues regarding patient privacy and your rights under the Federal privacy standards is UCP's HIPAA Compliance Officer, @ (256) 852-5600.

*The rights described in this document cannot be waived.*

**EFFECTIVE DATE**

This Notice is effective April 14, 2003.

**IF YOU HAVE ANY QUESTIONS REGARDING THIS NOTICE,**

**PLEASE CONTACT UCP's HIPAA Compliance Officer @ 256-852-5600.**



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ACKNOWLEDGEMENT OF RECEIPT OF  
PATIENT PRIVACY NOTICE

I acknowledge that I have received on this date \_\_\_\_\_, a copy of UCP's  
Patient Privacy Notice dated **4/14/03**.

\_\_\_\_\_  
Client Name

\_\_\_\_\_  
Authorized Signature (client, parent or guardian)

Please print the name of the person signing below:

\_\_\_\_\_

Relationship to client: \_\_\_\_\_



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## **Therapy Charges**

### **Speech Therapy**

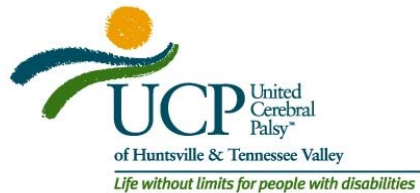
Evaluation (1 hour)	\$100.00
30 minute session	\$60.00

### **Physical Therapy**

Evaluation (1 hour)	\$100.00
30 minute session	\$70.00

### **Occupation Therapy**

Evaluation (1 hour)	\$100.00
30 minute session	\$70.00



## *UCP of Huntsville & Tennessee Valley, Inc. (UCP) Programs and Services*

### **Early Intervention**

UCP's Early Intervention program focuses on identifying developmental delays in children from birth to three years of age, developing a treatment plan, and providing appropriate therapy and intervention services to fit individual needs. Parents and families are also provided with disability education and training. In addition, a preschool readiness playgroup is offered weekly for children 18 months to three years of age to provide children with the enjoyable learning experiences and the socialization skills needed to enter a traditional classroom setting.

### **Outpatient Therapy**

This service provides therapeutic evaluations and direct treatment, including physical, occupational and speech therapies, for individuals of all ages. UCP of Huntsville & Tennessee Valley, Inc. features the latest in therapeutic equipment for its clients. When a physician prescribes outpatient therapy, young children with disabilities may also be provided with splinting and casting services to allow for proper bone growth and development. Computerized gait analysis and neuromuscular electrical stimulation services are available.

### **Children's Therapy Services**

Therapy services are also offered to typically developing children with short-term injuries due to sports and childhood accidents. Services offered for children ages birth to 16 years include pediatric physical, occupational and speech therapies and are available upon physician referral.

### **CCEP (Childcare Enhancement with a Purpose)**

UCP offers training to childcare providers across the Tennessee Valley to help create an inclusive environment for children with special needs. The CCEP program provides on-site training, consultation and technical assistance to preschools, daycares and other childcare providers. More than 3,000 North Alabama children and childcare providers benefit annually from this basic child development and inclusion education and training.

### **T.A.S.C. (Technology Assistance for Special Consumers)**

T.A.S.C. helps individuals with disabilities obtain and use technology to improve their independence at home, school and work. T.A.S.C. offers a fully accessible computer and training lab, state-of-the-art technology and equipment loans, adaptive literature, teacher and professional training, community-based demonstrations, adaptive technology evaluations and outreach, all for minimal or no cost to clients.

### **Family Connections**

This program provides parenting sessions with a licensed counselor, family outings for networking and support, mentoring between new and veteran families within the disability community, resource information and referrals.

### **Equipping Families for Success**

A licensed counselor is available for direct and/or group counseling for families affected by a disability. A parent support group meets weekly.

### **Young Adult Connections**

Young Adult Connections is a monthly peer support group for young adults with disabilities. The group meets at the UCP Therapy Center and presents speakers from the community, as well as provides a forum to discuss a variety of social, emotional and job readiness topics.

### **Equipment loan and recycling programs**

The Waste Not and SHARE (Special Help with Adaptive Resources & Equipment) programs allow UCP to assess, demonstrate and loan durable medical and mobility equipment to individuals with disabilities.

### **H.E.A.R.T.S. (Help Emergency and Respite Treatment Service)**

The H.E.A.R.T.S. program is designed to provide respite care for families of children with special needs up to age 19. Skilled respite is provided by licensed nurses or nursing assistants through local home health agencies. A voucher system allows parents to secure a caregiver of their choosing with payment by voucher.

### **Alabama Respite**

The Alabama Lifespan Respite Resource Network (Alabama Respite) was created to identify respite resources across the state, develop a directory of those resources that is easily accessible by caregivers, and assist communities in developing additional respite services. The program expanded in order to help develop new resources, train caregivers and offer technical assistance and training to respite providers. A voucher system allows families to secure a caregiver of their choosing with payment by voucher for adults age 19 and older with disabilities.

### **Art Stops**

UCP clients and their siblings ages three and older are invited to participate in free art workshops taught by local artist S. Renee' Prasil. Children are given opportunities to express their creativity, learn about textures, colors and shapes while developing their fine motor and language skills in a fun environment.

**Camp “I Can”**

Attending day camp for one week each summer at UCP is a much anticipated event for many of our community’s children with special needs. Camps feature theme-based language, motor and sensory activities through arts and crafts, games, movement, music, snacks and computer time. The camps are staffed by physical, occupational and speech/language therapists, special educators and qualified volunteers. Community visitors also share their talents with the children to provide music, movement and art experiences. Two different sessions are scheduled based on client ages and developmental needs.

**Call the UCP Therapy Center at 256-852-5600 and the UCP Technology and Training Center at 256-859-4900 for more information.**