Region 1 Application for Services
(Confidential Information)

(dd/rev: 1/2013)

Completed by: Relationship:
Service Coordinator: Date completed:
Agency:
Address: Phone # (w/ Ext.): Fax #: E-Mail:

Application Data

NAME: Phone #: Tabs #: **DOB:** Primary Language:
Address: Current Living Situation:
City: County: Zip Code: Gender: Birth Date:
Citizenship: Religion: Social Security #: Medicaid#:

Developmental Disabilities

Intellectual Disability: (Select One) ☐ Mild ☐ Moderate ☐ Severe ☐ Profound
Epilepsy: ☐ Cerebral Palsy: ☐ Autism: ☐ Neurological Impairment: ☐ Psychiatric diagnosis: Other:
Verbal: Non-verbal (please specify):
Ambulatory: ☐ Yes ☐ No Stairs: ☐ Yes ☐ No - Explain any Mobility Supports needed:
Level of Supervision required in the **Home**:
Level of Supervision required in the **Community**:

Number of adults residing in home receiving services:
Number of children residing in home receiving services:
Do these children receive OPWDD services? ☐ Yes ☐ No
☐ **Family** ☐ **Caregiver** ☐ **Emergency Contact** (Select One)
Name: Relationship: Primary Language:
Address: City: Zip:
Home #: Work #: E-Mail:
☐ **Legal Guardian** ☐ **Advocate Information** (Select One)
Name: Phone #: Primary Language:
Address: City: Zip:
Home #: Work #: E-Mail:

Emergency Information

Hospital:
Health Insurance Co.:
Policy #: Name on Policy:
Medicare #: Medicaid #:
DNR Order: ☐ Yes ☐ No Health Care Proxy: ☐ Yes ☐ No Living Will ☐ Yes ☐ No

Medical Information (attach any additional information)

Name of Primary Physician:
Address: Date Last Seen:
Name of Dentist:
Address Date Last Seen:
Additional Physicians (i.e.: psych)
Physician: Specialty:
Physician: Specialty:
Physician: Specialty:

Present Medications

Pharmacy: Phone #:

Drug	Dosage	Times Given	Reason	How Administered/By Whom	Route Given
1)					
2)					
3)					
4)					
5)					
6)					

Height: Weight: Seizures: ☐ Yes ☐ No *Description:*
Visual Impairments: ☐ Yes ☐ No Wears Glasses: ☐ Yes ☐ No Legally Blind: ☐ Yes ☐ No
Hearing Impairments: ☐ Yes ☐ No Wears Hearing Aid: ☐ Yes ☐ No

Allergies: ☐ Yes ☐ No

Allergy	Typical Reaction	Treatment

Special Medical Needs

Suctioning: ☐ Yes ☐ No Respiratory Therapy: ☐Yes ☐No Injections: ☐Yes ☐No Oxygen: ☐Yes ☐No
Dressing/Wound Care: ☐Yes ☐ No
Other:
Health Concerns:
Surgical History:

Income Sources (Residential Only)

SSI $ SSD $ Public Assistance $ Food Stamps $ Other income $
Waiver enrolled: ☐Yes ☐No Other Funding Source:
Assets (Life insurance, trust funds, Burial funds, Property, CD's):

Transportation Abilities (Circle all that apply)

☐Public Transportation ☐Family provides transportation ☐Medicaid cab ☐Drives own car
☐Other:

Current Agency Affiliations (i.e.: OPWDD, DSS, CASA)

Service Provided: Agency Providing:
Address:
Phone #: Contact Name:
Service Provided: Agency Providing:
Address:
Phone #: Contact Name:
School / Day Service:
Address:
Phone #: Contact Name:

Fire Evacuation Ability

Will respond to fire alarm ☐Yes ☐No Will leave house independently ☐Yes ☐No Needs help to leave ☐Yes ☐No
Verbal prompts ☐Yes ☐No Physical assistance ☐Yes ☐No
Total Assistance ☐Yes ☐No

Meal Time

	Independent	Needs Help	Dependent		Independent	Needs Help	Dependent		Independent	Needs Help	Dependent
Feeds Self	☐	☐	☐	Drinks	☐	☐	☐	Pours Drink	☐	☐	☐
Cuts Food	☐	☐	☐	Cleans Self	☐	☐	☐	Bottle Fed	☐	☐	☐

	Yes	No		Yes	No		Yes	No
Utilizes G- Tube feeding:	☐	☐	Spoon:	☐	☐	Fork:	☐	☐
Adaptive Feeding Equipment:	☐	☐	Plate:	☐	☐	Cup:	☐	☐

Other:

Are there any difficulties eating due to: (Check all that apply)

☐Drooling ☐ Bite Reflex ☐Gagging ☐ Chewing ☐Sucking ☐Choking ☐Swallowing ☐Unable to close mouth
☐Biting pieces of food ☐ Eats slowly?
Describe how to best assist the person during eating:
Special Diet: Food Allergies:
Favorite Foods: Disliked Foods:

Dressing / Toileting

Wears briefs/Diapers: ☐ Yes ☐No Toilet Schedule: ☐ Yes ☐No Adaptive Equipment: ☐ Yes ☐ No

	Independent / Needs help / Dependent				Independent / Needs help / Dependent				Independent / Needs help \ Dependent		
Dresses self	☐	☐	☐	Zips	☐	☐	☐	Socks	☐	☐	☐
Pants	☐	☐	☐	Buttons	☐	☐	☐	Tie Shoes	☐	☐	☐
Shirt	☐	☐	☐	Undergarments	☐	☐	☐	Select Clothes	☐	☐	☐
Undresses self	☐	☐	☐	Manages clothing	☐	☐	☐	Washes hands	☐	☐	☐
Transfers from chair to toilet	☐	☐	☐	Initiates	☐	☐	☐	Manages toilet tissue	☐	☐	☐
Self toilets	☐	☐	☐								

Are there any special problems with bowel movements and/or urinary problems? (Explain)

Self - Care

	Independent / Needs help \ Dependent			Independent \ Needs help \ Dependent			Independent \ Needs help \ Dependent		
Washes Body	☐	☐	☐	Brushes Teeth	☐	☐	☐	Tub/Shower	☐	☐	☐
Shampoos Hair	☐	☐	☐	Combs Hair	☐	☐	☐	Menstruation Care	☐	☐	☐

Sleep Patterns

Wears to bed: Bedtime: Wake-up time:
Sleeps through the night: ☐Yes ☐No Uses bed rails: ☐ Yes ☐ No Door: ☐ Open ☐Closed
Lights: ☐ On ☐ Off Toileted/Changed during night: ☐ Yes ☐ No If yes, what times:
Naps: ☐ Yes ☐ No If yes, what times:
Bedtime routine / Problems:
Positioning:
Other:

Behavior

Indicate frequency of behavior by using code: D = Daily, W = Weekly, M = Monthly, N/A = Not Applicable
No Problems: Eats In-edibles: Wanders/runs away:
Destroys property: Non-compliance: Bites:
Inappropriate sexual behavior: Other:
Hits / Kicks: Verbal Abuse: Self injurious behavior:
Smokes: Pulls Hair: Spits:
Precipitating factors/causes:
How are these behaviors supported?
Reinforcers:
Sexuality – Consenting: ☐Yes ☐No Comments:
Interests or Hobbies (please explain):
Dislikes (please explain):
Fears (please explain):

Additional information not previously covered:

Any Legal Issues (Please Explain):

Residential Need

Group setting: ☐ Individual Residential Alternative (IRA) ☐ Intermediate Care Facility (ICF) ☐ Family Care
Apartment style: ☐ Supportive ☐ Supervised ☐ All Male ☐ All Female ☐ Co-Ed Shares Bedroom: ☐ Yes ☐ No
Activity in Home: ☐ Very Active ☐ Fairly Active ☐ Less Active
NY State Cares enrolled: ☐ Yes ☐ No
Other Information (i.e.: pets):
Reason for Residential Request:
County Preference: ☐ Allegany ☐ Cattaraugus ☐ Chautauqua ☐ Chemung ☐ Erie ☐ Genesee ☐ Livingston ☐ Monroe ☐ Niagara
☐ Ontario ☐ Orleans ☐ Schuyler ☐ Seneca ☐ Stueben ☐ Wayne ☐ Wyoming ☐ Yates
How soon is placement desired: ☐ Urgent ☐ Under 2 years ☐ 3-5 years ☐ 5 or more years?

Services Requested

Respite:	Habilitation:	Behavior Services:
☐ Respite – In Home	☐ Day Habilitation (Group)	☐ Enhanced Supported Employment**
☐ Respite - Out of Home	☐ Community Habilitation	☐ Intensive Behavior Support**
☐ Respite – Weekend	☐ Assistive Supports	** If this service is requested, please attach updated DDP-2
☐ Respite – After School	☐ Day Habilitation (Supplemental)	& OPTS Non-IRA enrollment form.
☐ Prevocational	☐ Supported Employment (SEMP)	

Number of Respite Hours: Requested Start Date:
Number of Community Habilitation (Res Hab) Hours:

Explain in detail the goal of utilizing this service, and how efficiency of such will be measured:

Please attach current ISP/addendum, DDP1, transmittal sheet, and **DDP-2 & OPTS Non- Enrollment form (as applicable)

Submitted by (Signature):

Provider Agency:

Supervisor Signature / Date:

Consent / HIPPA

Consent for Residential
I give permission to share necessary information with any OPWDD or Voluntary agency that may have a vacancy.
(Signature below)

Privacy Notice – Acknowledgment Receipt
New federal regulations require OPWDD to send a Privacy Notice to everyone who receives services from OPWDD. These regulations are known as the HIPPA Privacy Rule. HIPPA is short for the Health Insurance Portability and Accountability Act of 1996.

The HIPPA Privacy Rule DOES NOT CHANGE the way you get services from OPWDD. It does not change the privacy rights that you have always had under the New York State Mental Hygiene Law. The HIPPA Privacy Rule requires OPWDD to take some additional steps to make sure you are aware of your privacy rights.

By signing this acknowledgement form, I am confirming that I have received a copy of the OPWDD's Privacy Notice and can contact the people listed in the Privacy Notice to get more in information about my privacy rights in OPWDD.

Signature: _____

Individual seeking services: _____

Relationship to Individual seeking services: _____

Date: _____