Region 1 Application for Services **(es/rev: 10/1/14)**
(Confidential Information)

Application Data

NAME: Phone #: Tabs #:
DOB: Primary Language:
Current Living Situation:
Address:
City: County: Zip Code:
Gender: Birth Date:
Citizenship: Religion:
Social Security #: Medicaid#:
Attended Family Information Session:
Scheduled for Family Information Session:

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

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 (Check 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:

Legal Issues

Mental Hygiene Arrests (Explain): ☐ Corrections (Explain): ☐ Orders of Protection (Explain): ☐
Charges (Explain): ☐ Probation (Explain): ☐ SORA Status (Explain): ☐

Residential Need (check all that apply)

Group setting: ☐ Individual Residential Alternative (IRA) ☐ Family Care ☐ CSS Plan ☐ Non-Certified

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: ☐ Aging Out ☐ Individual's Medical Concerns ☐ Caretaker's Medical Concerns
☐ Risk Behavior in Home ☐ Legislative Mandate ☐ Other

County Preference: ☐ Allegany ☐ Cattaraugus ☐ Chautauqua ☐ Chemung ☐ Erie ☐ Genesee ☐ Livingston ☐ Monroe ☐ Niagara
☐ Ontario ☐ Orleans ☐ Schuyler ☐ Seneca ☐ Steuben ☐ Wayne ☐ Wyoming ☐ Yates

How soon is placement desired: ☐ Meets Urgent Criteria ☐ Immediate ☐ 1 year ☐ Under 2 years

Submitted by (Signature):

Provider Agency:

Supervisor Signature / Date:

Consent / HIPPA

Consent for Residential
The Referral process has been explained to me in its entirety. I give permission to share necessary information with any OPWDD or Voluntary Agency that may have a vacancy in order to identify an appropriate residential opportunity for this individual.
(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: ____