Application for Services

For Families and Agencies in the Capital District

This application (or a copy) can be used to apply to all agencies in The Capital District DDSO

Attachments to be submitted with the application

1. **Copy of a recent physical examination**
2. **Copy of recent psychological evaluation that clearly states disability**
   - **If the individual has developmental disabilities, must document onset of disability prior to the age of 22**
   - **Include adaptive behavior scale (usually done as part of the psychological evaluation)**
3. **Copy of Individualized Service Plan (ISP) or Comprehensive Social History**
4. **Copy of Program (IEP, Day Services Plan, etc.) as Applicable**
5. **Copy of DDP-4 if available**
6. **Copy of NYS Cares Priority Form if available (For residential referrals)**

Please retain a copy of the completed application for your own records

For Agency Use:

Is the individual on the NYS Cares Waitlist? **YES** **NO** **DON'T KNOW**

Priority Number:

Has a DDP 4 been submitted? **YES** **NO** **DON'T KNOW**

If Yes, by which agency?

Universal Application

For Families and Agencies in the Capital District

Date Received: ____________________

SERVICES YOU ARE INTERESTED IN RECEIVING: (Check all that apply)

[ ] Day Services [ ] Residential Services [ ] In-Home Services [ ] Respite [ ] Recreation

[ ] Service Coordination [ ] Supported Employment [ ] Family Support Services [ ] Clinic Services

[ ] Other (describe) ____

____

What is your timeframe? ____

APPLICANT DATA:

Name: ______________________ Birth date: __________ Gender: Male Female (circle one)

Address: ______________________ Marital Status: ______________________

______________________ U.S. Citizen? Yes No (Circle One)

______________________ Soc. Sec. #: ______________________

County of Residence: ______________________ Telephone # ( ) ______________________

Does applicant have dependent children? Yes No How many? __________

CONTACT: **(Parent, Guardian, Caregiver)**

Name: ______________________ Relationship: ______________________

Address: ____

____

Day Telephone # ( ) ______________________ Eve Telephone # ( ) ______________________

REFERRAL SOURCE:

Name of Agency or School: ____

Contact Person: (if different from above) ____

Address: ____

Phone # ( ) ______________________

LEGAL GUARDIAN (COURT APPOINTED IF OVER 18):

Name: ______________________ Phone # ( ) ______________________

Address: ____

MEDICAL INFORMATION:

Developmental Disability/Diagnosis: ____________________

Medical Diagnosis: ____________________

Psychiatric Diagnosis: ____________________

History of Hospitalization ____________________
(medical and/or psychiatric)
____

MEDICATION(s):

Name: ____________________ Reason for Medication: ____________________

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Name: ____________________ Reason for Medication: ____________________

Ongoing Medical Treatments needed: (G-Tube feeding, Chemotherapy, Kidney Dialysis, etc.)

____

____

Allergies: (food, medication. Other): ____________________

Date of last Tetanus: ____________________ TB Status (last Screening): ____________________
(Please be aware that a current PPD or Mantoux, and a HEP B screen will be required for most programs prior to admission)

Circle the response that best describes applicant's functioning in the following areas (indicate the one that best applies)

1. Hearing deficit Yes No
2. Visual deficit Yes No
3. Walking ability
   - a. Independent
   - b. With difficulty
   - c. Corrective device
   - d. Assistance from Caregiver
   - e. Cannot walk
4. Can independently climb stairs? Yes No
5. Does applicant use a wheelchair? Yes No

Mark the one response that best describes wheelchair (may e motorized) mobility:

1. Can use wheelchair independently, including transfer.
2. Can use wheelchair independently with assistance in transferring.
3. Requires assistance in transferring and moving.
4. No Mobility – Must be transferred and moved.

Comments: ____

____

Describe any adaptive equipment used: ______________________________

____

____

PRIMARY PHYSICIAN:

Name: ____________________ Phone: ( ) ____________________

Address: ____

OTHER SPECIALISTS:

Name: ____________________ Phone: ( ) ____________________

Address: ____

Name: ____________________ Phone: ( ) ____________________

Address: ____

EDUCATIONAL/VOCATIONAL INFORMATION: (Begin with the most recent. List name of school/program or employment, type of class, dates of attendance, etc.)

1. ____

____

2. ____

____

3. ____

____

Does the applicant have an open VESID case? Yes No

Name of Counselor: ____________________

COMMUNICATION SKILLS:

Verbal:________________________ Describe level of ability:______________________________________

Primary Language (Spoken)______________________________________

(Understood)__________________________________

Non-Verbal:____________________ Uses Sign Language____

Describe how much sign is used or other methods of communication:

____

____

Additional Comments:

____

____

DAILY LIVING SKILLS:

What assistance does the applicant need in the area of Toileting?_________________________________

____

What assistance does the applicant need for Eating/ Drinking?____________________________________

____

What assistance does the applicant need to be safe in the home?_________________________________

____

What assistance does the applicant need to be safe in the community?_____________________________

____

RECREATION / LEISURE TIME ACTIVITIE:

1. What does the applicant enjoy doing in their spare time?____________________________________

____

2. What activities does the applicant have an interest in doing or achieving? (Learning to cook, exercising, learning to read, etc.):

____

____

BEHAVIORS: For each, describe what causes the behavior, how often it happens, and how severe it is.

1. Aggressive Behaviors (verbal/physical) ______________________________

____

____

2. Damages own or others property

____

____

3. Injury to self (include eating inedible objects)

____

____

4. Refuses to follow direction or accept supervision or help:

____

____

5. Sexually inappropriate behaviors:

____

____

6. Runs or Wanders Away

____

____

7. Takes belongings of others

____

____

8. Other

____

____

What methods do you use to deal with challenging behaviors the individual presents?

____

____

SUBSTANCE ABUSE

Are there or have there ever been any concerns with substance abuse, including alcohol? Yes No

If yes, Please explain____

____

CRIMINAL JUSTICE

Has the applicant ever been involved with the criminal justice system? Yes No

If yes, Please explain____

____

FINANCIAL BENEFIT INFORMATION:

Applicant receives Supplemental Security Income (SSI) Yes No

Applicant receives Social Security or Disability Benefits (SSA, SSDI) Yes No

Applicant currently receives Medicaid Yes No

Medicaid #______________________________ County:____________________________

Applicant currently receives Medicare Yes No

Medicare #:______________________________

Applicant is covered under Other Health Insurance Yes No

Insurance Company____

Policy Holder______________________________ Date of Birth__________________________

Policy Number:____________________________ Group Number_________________________

Applicant receives Benefits/Income not listed (Veteran's, Railroad, Trust Fund)

____

____

Is there any additional information you wish to share that is not included in this application?

____

____

____

____

Are you currently receiving services from any other agency? Yes No
(Service Coordination, Reshab, Respite, etc.)

Is the applicant HCBS enrolled? Yes No Don't Know

Agency Name:____

Type(s) of Service:____

Name of Contact:__________________________ Phone: ( )______________

I hereby verify that all of the above information is correct and accurate to the best of my knowledge.

Applicant:______________________________ **Date:**____________________

Parent/ Guardian__________________________ **Date:**____________________
(if applicable)

Person completing application:______________________________________

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