

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?

AGENCY NAME (optional)

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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? In the next 2 years

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:

Address:

Phone #

LEGAL GUARDIAN (COURT APPOINTED IF OVER 18):

Name: Phone #

Address:

AGENCY NAME (optional)

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MEDICAL INFORMATION:

Developmental Disability/Diagnosis:

Medical Diagnosis:

Psychiatric Diagnosis:

History of Hospitalization:
(Medical and/or psychiatric)

MEDICATION(s):

Name: Reason for Medication:

Name: Reason for Medication:

Name: Reason for Medication:

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

Allergies: (food, medication. Other): Dust Mites

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 | d. Assistance from Caregiver | |
| b. With difficulty | e. Cannot walk | |
| c. Corrective device | | |
| 4. Can independently climb stairs? | Yes | No |
| 5. Does applicant use a wheelchair? | Yes | No |

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:

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: _____

AGENCY NAME (optional)

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.):

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?

AGENCY NAME (optional)

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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AGENCY NAME (optional)