

Catholic Charities Disabilities Services'
In-Home Behavioral Support Services
(2026)

A Program funded through a Family Support Services Grant from OPWDD

Submit Application and supporting documentation to:

Kimberly Hacker

IHBS Supervisor

Catholic Charities Disabilities Services

1 Park Place, Albany, NY 12205

(518) 783-1111; Fax # (518) 785-4894; Email kimberlyh@ccdservices.org

Date: _____

Section I

Name of person completing the application:

Affiliation (e.g. agency name):

Phone Number:

E-mail Address:

Section II

Individual's Name:

Date of Birth:

Age:

TABS #:

Individual's Phone #:

Individual's Address:

City:

Zip:

Individual's County of Residence:

Gender:

Is the Individual Waiver Enrolled?

Yes No

Individual's Medicaid #:

List the individual's school, if he/she is attending one:

Contact to setup initial assessment:

Name:

Telephone #:

Relationship to Individual:

Email address:

Section III

1. What is the individual's living arrangement?

Lives with family Lives with roommates Lives by him/herself Other:

2. What OPWDD services does the individual receive, if any?

<input type="checkbox"/> Group Day Habilitation	<input type="checkbox"/> Supported Employment	<input type="checkbox"/> Supplemental Group Day Habilitation
<input type="checkbox"/> Prevocational Services	<input type="checkbox"/> Family Supports Services	<input type="checkbox"/> Supplemental Individual Day Habilitation
<input type="checkbox"/> Family Education & Training	Individual Day	<input type="checkbox"/> Community Habilitation
<input type="checkbox"/> Respite	<input type="checkbox"/> Habilitation Service	<input type="checkbox"/> Individual Support and Services
<input type="checkbox"/> Self-Directed Services	<input type="checkbox"/> Care Management	Other:

3. What clinical services does the individual receive, if any?

<input type="checkbox"/> Social Work	<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Physical therapy
<input type="checkbox"/> Psychology/Psychiatry	<input type="checkbox"/> Speech Therapy	<input type="checkbox"/> Other Clinical Services:

4. What other services does the individual receive, if any? These services may include ones that the individual receives through another governmental agency (e.g. Department of Health or the individual's county of residence).

--

5. What is the individual's diagnosis/diagnoses?

6. List any medications that the individual is currently taking and the reason.

7. Provide a brief narrative of the individual's behavior(s) that would be addressed through In Home Behavioral Support Services. Note: Please add any safety concerns and/or needs

8. Other supporting materials for submission:

- OPWDD Eligibility Approval (required)
- Life Plan (required)
- Clinical Records
- Other psychosocial history records
- Individualized Education Plan (IEP), if applicable
- Self-Direction Budget, if applicable

Previously completed Functional Behavioral Assessment(s) and/or Behavioral Plan(s)

*****Please highlight information which may be particularly helpful in relation to your request.***

9. What behavioral services is the person currently receiving?

In Home Behavioral Supports	Occupational Therapy	None
Intensive Behavior Supports	Applied Behavior Analysis	Other _____

10. Where are these services provided?

11. What behavioral services has the individual received in the past? Where were they provided?

12. Is the individual currently enrolled in Self-Direction?

If yes, please include a copy of the Self-Direction Budget. To become enrolled, IHBS will need to be included in the Self-Direction Budget

Signature of person completing the form

Date

Signature of Parent(s) or Individual

Date