Catholic Charities Disabilities Services'

In-Home Behavioral Support Services

(2025)

A Program funded through a Family Support Services Grant from OPWDD

Submit Application and supporting documentation to:

Sean Hartz

IHBS Supervisor

Catholic Charities Disabilities Services

1 Park Place, Albany, NY 12205

(518) 424-7063; Fax # (518) 785-4894; Email IHBSinfo@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?**
   ☐Group Day Habilitation ☐Supported Employment ☐Supplemental Group Day Habilitation
   ☐Prevocational Services ☐Family Supports Services ☐Supplemental Individual Day Habilitation
   ☐Family Education & Training Individual Day ☐Community Habilitation
   ☐Respite ☐Habilitation Service ☐Individual Support and Services
   ☐Self-Directed Services ☐ Care Management Other:

3. **What clinical services does the individual receive, if any?**
   ☐Social Work ☐Occupational Therapy ☐Physical therapy
   ☐Psychology/Psychiatry ☐Speech Therapy ☐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**