5/1/11

UNIVERSAL APPLICATION

This application can be used to apply for services to all agencies in the Capital District DDSO.
Please retain a copy of the completed application for your records.

Name of Individual: _____ **Date**: _____

Attachments to be submitted with the application: *(Please check off)*

- Cover letter (Describe current circumstances and reason for requested services)
- Recent Physical Exam (Required)
- Copies of two (2) most recent PPDs (Signed by provider)
- Specialized medical consultation(s) (If applicable)
- Most recent Psychological Evaluation that clearly states disability
  - If developmental disabilities exist, must document onset of disability prior to age 22
  - Include Adaptive Behavior Scale
- Proof of OPWDD Eligibility
- HCBS Waiver Notice of Decision (If applicable)
- Behavior Support Plan/Risk Assessment and plan (If applicable)
- Psychiatric consult (If applicable)
- Mental health treatment records (If receiving counseling)
- Copy of most recent Individualized Service Plan (ISP) or IEP, Comprehensive Social History/Clinical Reports
- Copy of most recent Day Services report (If applicable)
- Copy of DDP-4 reflecting identified need for services
- Copy of NYS Cares Priority form indicating priority level (Residential referrals only)

Referral Source:

Name of agency: _____

Contact Person: _____

Address: _____

Phone # (_____) _____ Fax # (_____) _____

Services you are requesting: (Check all that apply)

[ ] Day Services [ ] Residential [ ] Community Habilitation [ ] Respite [ ] At Home respite

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

[ ] Clinic Services [ ] Other _____

Are you currently receiving any other services? Yes/No

Type: _____ Agency providing service: _____

Name_____

Applicant Data:

Name: _____ Birth date: _____ Gender: Male/ Female

Tabs ID # _____ Waiver enrolled: Yes/No US Citizen: Yes/No

Phone # (_____) _____ Religious preference: _____

Address: _____

County of residence: _____ Marital Status: _____

Does applicant have dependants? Yes/No If yes, how many? _____

Does the applicant have siblings? Yes/No _____

Financial Benefit Information:

Does applicant receive: Social Security #:_____

Supplemental Security Income (SSI)? Yes/No Social Security or Disability Benefits (SSA, SSDI)? Yes/No

Medicaid? Yes/No Medicaid # _____ County _____

Medicare? Yes/No Medicare # _____

Other benefits (Veterans, Railroad)? Yes/ No _____

Does the applicant have earned income? Yes/No Checking/ Savings account? Yes/No

Other Health Insurance Yes/No If yes: Company: _____ Policy Holder: _____

Policy Number: _____ Policy Holder's DOB:_____ Group # _____

Does applicant have a burial fund? Yes/No Life Insurance? Yes/ No

Contact Information: (Parent, Guardian, Caregiver, Advocate)

Name: _____ Relationship: _____

Address: _____

Home # (_____) _____ Cell# (_____) _____

Legal Guardian (Court Appointed if over 18): (Include Guardianship paperwork if applicable)

Name: _____ Home # (_____) _____ Cell # (_____) _____

Address: _____

Name_____

Medicaid Service Coordinator:

Name: _____ Phone: (_____) _____

Email: _____

Agency/Address: _____

Primary Physician:

Name: _____ Phone: (_____) _____

Address: _____

Specialists:

Name: _____ Discipline: _____

Address: _____

Phone: (_____) _____

Name: _____ Discipline: _____

Address: _____

Phone: (_____) _____

Name: _____ Discipline: _____

Address: _____

Phone: (_____) _____

Name: _____ Discipline: _____

Address: _____

Phone: (_____) _____

Name: _____ Discipline: _____

Address: _____

Phone: (_____) _____

Educational/Vocational Information: (Most recent first - list name, type and dates)

1. _____

   *If applicant is still in high school, list anticipated date of graduation & home school district.

2. _____
3. _____
4. _____

Name_____

Does applicant have an open VESID case? Yes/No

Does applicant have Supported Employment? Yes/No Name of agency: _____

Medical Information:

Developmental Disability/Diagnosis: _____

Medical Diagnosis: _____

Psychiatric Diagnosis: _____

Recent hospitalizations (medical and/or psychiatric): _____

_____

Hearing deficit Yes/No Comment: _____

Visual deficit Yes/No Comment: _____

Walking ability: [ ] Independent [ ] With difficulty [ ] Assistance needed [ ] Cannot walk

Can applicant climb stairs? Yes/No

Does applicant use a wheel chair? Yes/No If yes: Motorized? / Manual? If yes, select best description:

[ ] Independently (including transfers) [ ] Independently with assistance in transfers

[ ] Requires assistance in transferring and moving [ ] No mobility

Comments: _____

Adaptive equipment used: _____

Medications:

Name: _____ Reason: _____

Name: _____ Reason: _____

Name: _____ Reason: _____

Name: _____ Reason: _____

Name: _____ Reason: _____

Ongoing medical treatments needed: (Insulin, tube feeding, dialysis, etc)

_____

_____

Allergies: (food, medication, other) _____

Name_____

Communication Skills:

[ ] Verbal Level of ability: _____

[ ] Non verbal Uses Sign Language? Yes/No _____

Other device used to communicate? _____

Primary language spoken: _____ Understood: _____

Daily Living Skills:

What assistance does applicant need in area of:

Toileting: _____

Eating/Drinking: _____

What supports does applicant need to be safe in home? _____

What supports does applicant need to be safe in community? _____

Recreation/ Leisure activities:

What does applicant enjoy doing in spare time? _____

_____

What activities does the applicant have an interest in learning or doing? (cooking, exercise, learning to read)

_____

_____

Behaviors: (For each yes, describe what causes the behavior, how often it happens and effective interventions)

- Verbal Aggression Y/N _____
- Physical aggression Y/N _____
- Damages property Y/N _____
- Self abusive Y /N _____
- PICA Y/N _____
- Runs/ Wanders away Y/N _____
- Take others belongings Y/N _____
- Refuses direction Y/N _____

Name_____

Sexually inappropriate behaviors? Yes/No If yes, comment thoroughly on type, how often, target and effective intervention. _____

_____

_____

Has the applicant had any issues with substance abuse? Yes/No If yes, comment thoroughly on type, how often, treatment and effective intervention. _____

_____

_____

Has the applicant had any criminal justice issues? Yes/No If yes, comment thoroughly on type, dates, and any follow up (probation, jail time) _____

_____

_____

Any additional information you wish to share that is not included: _____

_____

_____

_____

This application can be used to apply to all agencies in the Capital District DDSO.

Applicant: _____ Date: _____

Parent/Guardian: _____ Date: _____

(If applicable)

Person completing application: _____ Date: _____

Please bring this form to your initial intake appointment.