UNIVERSAL APPLICATION

If you need assistance filling out this application please contact your MSC or the LIDDSO Intake Unit (631-434-6000)

APPLICANT'S INFORMATION

Name: _____Date: _____

Current Address: _____

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ Birthplace:_____

Tabs ID # (if known) _____ Email : _____

OPWDD Eligibility Yes/No If yes as of what date_____

Does applicant have a Medicaid Service Coordinator□ Yes □ No

Agency Name: _____

Name of Medicaid Service Coordinator: _____ Phone: _____

Is the applicant enrolled in the HCBS Waiver□ YES □ NO Enrollment Date:_____

DISABILITIES

(*Please check all that apply*)

_____Age of Onset of Primary Disability

__Intellectual Disabilities (ID) (Formerly MR)
__Epilepsy/Seizure Disorder
__Autism
__Asperger's Syndrome
__Cerebral Palsy
__Familial Dysautonomia
__Down's Syndrome
__Learning Disability
__Sensory Impairment
_Physical/Medical Condition
__Psychiatric Disability *(Secondary to Dev. Dis.)*
__Traumatic Brain Injury *(Prior to age 22)*
_Tourette syndrome
__Spina Bifida
__Prader Willi
__Other Neurological Impairment (Please explain :_____)

COGNITIVE ABILITY

Verbal I.Q._____ Performance I.Q._____ Full Scale I.Q._____
Vineland II Adaptive Score_____ ID Level: _____

BENEFIT INFORMATION

US Citizen or National: Yes or No Lawful Permanent Resident #: **A**_____
Social Security #_____

Is the applicant covered by Medicaid □Yes □ No
If YES: Medicaid Identification Number (CIN)_____ Date Approved:_____
HMO Plan (if applicable)_____
If NO: Was a Medicaid application filed? □Yes □ No If YES, complete the following:
Date of application: _____Date of denial: _____
Reason for denial: _____

Medicare #_____Parts A/B/D Part D Drug Plan: _____

Primary Insurance_____Policy Holder:_____

Policy #_____Group #_____

SSI Benefits: Yes / No SSD Benefits: Yes /No Supplemental Needs Trust (SNT): Yes/No

Representative Payee for Benefits:
Name:_____

Address_____

Phone: _____

Is the applicant Employed Yes/No: If Yes: Where_____

APPLICANT'S CURRENT DAY ACTIVITY (check all that apply)		
□ School (graduation year____) School Name _____ Tel # _____ Financially responsible school district Name:_____ Tel #: _____	□Day Program Program Name: _____ Tel # _____ Days Scheduled: _____	□ Place of Employment Employer _____ Tel # _____ Days Scheduled: _____

PARENT / GUARDIAN / CAREGIVER INFORMATION

Mother	Father
Name:	
Address:	
Home Phone:	
Work Phone:	
Cell Phone:	
E-Mail:	

Court Appointed Guardian? Yes /No If Yes relationship: _____
If Yes: Date in which court?

If there is a court appointed guardian(s), please provide a copy of the guardianship papers.

Siblings

Name:_____ Age:_____ Reside at Home:___

Name:_____ Age:_____ Reside at Home:___

Other Household Members / Other Primary Care Giver

Name: _____ Relationship to applicant: _____

Home #: _____ Work #: _____ Cell #: _____

Who of the above is the primary contact person and when is the best time to call? _____
_____

Emergency Contact Details:

Name: _____ Relationship: _____Phone #: _____

Name: _____ Relationship: _____Phone #: _____

PERSONAL INFORMATION

Gender: Male □ Female □ Height: _____ Weight: ____ Hair Color: _____ Eye Color: _____

Identifying Marks or Features: _____

Ethnicity/Race: check all that apply - Answers to these questions will not affect eligibility for services

□ White	□ Asian or Pacific Islander
□ African American	□ American Indian/Alaskan
□ Hispanic	□ Other
Religion:	

SENSORY SKILLS

Which best describes the applicant's hearing?	□ Normal □ Mild/Moderate □ Severe/Profound loss □ Sensitivity to Noise
Does the applicant use a hearing aid?	□ Yes □ No
Which best describes the applicant's vision?	□ Fully sighted □ Moderate impairment □ Severe impairment □ Blind
Does the applicant use glasses?	□ Yes □ No

COMMUNICATION

Check the responses that best describes the applicants method of communication

□ Verbal	□ Uses signs or communication device
□ Uses gestures, vocalizations	□ Unable to communicate

AMBULATION

_____Walks Independently _____Unsteady Gait _____Walks with Physical Assistance

_____Requires Use of Wheelchair _____Uses Other Adaptive Equipment to Ambulate *(If yes, please describe)* _____

ABILITIES AND STRENGTHS

Socialization: ___Indicate accordingly: 1. Never 2. Sometimes 3. Often 4. Always

___ Interacts with others	___ Displays affection appropriately
___ Maintains friendships	___ Greets appropriately
___ Occupies self independently	___ Is Cooperative
___ Initiates conversation	___ Accepts limitations
	___ Controls temper

Please include any other special socialization information that you consider important for the staff to be aware of.

_____

_____

SELF CARE

Indicate accordingly: 1. Independent 2. Needs supervision 3. Needs assistance 4. Completely dependent

___ Eating	___ Dressing
___ Toileting	___ Bathing / shower
___ Tooth brushing	___ Shaving
___ Menses	___ Administering medications

Please include any other special self care information that you consider important for the program staff to be aware of? _____
_____

BEHAVIOR PROFILE

(Please indicate frequency)

0=Never 1=Daily 2=Weekly 3=Monthly 4=Every 3 Months 5=Every 6 Months

_____No Problems	_____Physically Assaultive	_____Pica
_____Self-Injurious	_____Withdrawn	_____Fire Setting
_____Sleeping Disorders	_____Eating Disorder	_____Stealing
_____Verbally Abusive	_____Sexual Misconduct	_____Smears Feces
_____Temper Tantrums	_____Non-Compliance	_____Wanders
_____Destroys Property	_____Alcohol/Substance Abuse	_____Elopement
_____Enuresis	_____False Statements	_____Teasing
_____Impulsive	_____Mood Changes	_____Hyperactive

COMMENTS: Please indicate other pertinent information related to unusual or maladaptive behaviors and/or psychiatric symptoms (i.e., how often do behaviors/symptoms occur?)

_____

_____

_____

_____

MEDICAL HISTORY

Medical needs: Please list any medical conditions or needs that may impact the individuals, such as seizures or diabetes, etc.

_____

_____

_____

_____

Allergies:

Medication Allergies: _____ Reaction: _____

Food Allergies: _____ Reaction: _____

Environmental Allergies: _____ Reaction: _____

Other: Tuberculosis- Mantoux /TB/PPD skin test

- Reason for a Mantoux test:
  - New York State Health Department mandates this test to control and eradicate TB
- If the test results are Negative:
  - *As per the June 2010 regulation two negative PPD's are required. The first negative followed in 1-3 weeks by the second. If both negative this is documented & an annual screening by a health care provider is appropriate*.
- If the test results are positive:
  - If there is a positive PPD result, a chest x-ray (within two years) and a note from the doctor, within a year, stating the individual is clear of communicable diseases is required.
- If the family refused the PPD testing:
  - A note from the doctor, within a year, that the individual is clear of communicable diseases is required.

DOCUMENTATION MUST BE ATTACHED

NUTRITION

Please indicate if there are any special dietary requirements or any food restrictions.

_____

_____

_____

_____

MEDICAL / DENTAL PROVIDERS

Physician's Name: _____

Address: _____

Phone: _____

Dentist's Name: _____

Address: _____

Phone: _____

Psychiatrist's Name: _____

Address: _____

Phone: _____

Specialist's Name: _____

Specialty: _____

Address: _____

Phone: _____

Specialist's Name: _____

Specialty: _____

Address: _____

Phone: _____

Other Providers: _____

Address: _____

Phone: _____

Name Date

CURRENT MEDICATIONS

Medication	Dose (amt/frequency/time)	Prescribed By	Diagnosis

Please attached additional sheets if needed

DOCUMENTATION

Please be sure to attach copies of the documents indicated below. All information must be within the last 1 (one) year unless otherwise noted.

The following documents are required as part of the Universal Application

Required Document	**Document attached √**	**Date of document**
Annual Physical Exam		
Immunization (PPD info on page 6)		
Psychological Evaluation (Must be within 3 years)		
Adaptive Behavior Scale, ie., Vineland, ABAS, etc (Must be within 3 years) .		
Psycho-Social Evaluation (Must be within 3 years)		
***If you are applying for a HCBS Waiver program you MUST include the ISP**		
Level of Care Eligibility Determination (LCED) (if waiver enrolled)		
Notice of Decision (NOD) (if waiver enrolled)		
Copy of Medicaid Card (if applicable)		
OPWDD Eligibility Determination		
Privacy Practices Sign Off		
Signed consent for release of information		

The following are documents that may be required based on agency policies and the program for which you are applying for services:

Required Document	Document attached √	Date of document
Annual Dental		
Psychiatric Evaluation (if applicable)		
Annual ISP/IEP ISP Addendums must be submitted once applicant is accepted into a program		
Copy Social Security Card		
Copy Birth Certificate		
Copy of Social Security benefits award letter		
Liability Notices		

Signatures:

By signing below you agree that this application MAY be used to apply to all agencies in the Long Island DDSO; You also understand that additional paperwork may be needed for individual agencies and programs.

By signing below I confirm that the information provided in this application is complete and accurate to the best of my knowledge.
I understand that failure to provide comprehensive and accurate information may result in the applicant's non-acceptance into an agency's program.

Applicant:_____Date:_____

Parent/Advocate/Guardian:_____Date_____

Person completing application_____Date_____

Referred by:_____Phone_____

- For **MSC's** making the referrals be sure to obtain and fill in the Referral tracking log, which maybe a separate document or an attachment to this application.

Please select programs of interest			
Program		**Description**	**Area Served/Age Served**
□	Family Support Services (FSS)	LIFSSAC web site: http://www.lifssac.com/ LIFSSAC Grant List: http://www.lifssac.com/3.html Support services offered to developmentally disabled individuals that are living at home with their families. These services include: in home and out of home respite, recreational programs, crisis intervention, advocacy, sibling support, outreach, and resources. ***See description below of services but please note not every agency offers all services please contact the individual agency to ascertain what they offer.***	Please contact the individual agency to find out what FSS services they offer and what area of LI they serve.
	Family Support Service Programs		
□	After School/Respite Program & School Vacation Respite:	Provides services to developmentally disabled children or adults for several hours up to 5 days a week.	
□	Crisis Intervention	Services include behavioral assessment and intervention; training of families; linkage and referral; emergency in-home and out-of-home respite.	
□	Parent Training for DD Parents	Provides parent skills and training for parents with developmental disabilities.	
□	Family Counseling, Training & Advocacy	Provides counseling, training, behavior management and advocacy services for the family and the developmentally disabled person, at the agency site or in the home.	
□	In-Home Respite:	Matches trained respite workers with families to provide scheduled care for individuals with developmental disabilities in their homes.	
□	Overnight Freestanding Respite	Scheduled respite in certified agency operated respite homes, weekends or weekdays.	
□	Respite Recreation	Provides care through recreation and social activities at various agencies in Nassau and Suffolk Counties.	
□	Senior Day Programs	Social recreational day programs offered to seniors 45 years and up.	
□	Sibling Support:	Provides services to siblings through support groups, individual counseling or recreational activities.	
□	Town Recreation	Provides recreation and social activities to town residents with developmental disabilities.	
□	Voucher/ Reimbursement	Families are reimbursed for purchased goods or services for their developmentally disabled person which cannot be funded through other resources. Services in the grant are not reimbursable.	
□	Non-Medicaid Service Coordination	Short term service coordination to assist developmentally disabled individuals with the planning for and accessing of desired services and supports.	

Please select programs of interest			
Program		**Description**	**Area Served/Age Served**
Agency supported services.			
□	MSC (Medicaid Service Coordination)	A MSC assists eligible persons with developmental disabilities in gaining access to necessary supports and services appropriate to the needs of the individual. MSC is provided by qualified service coordinators and uses a person centered planning process in developing, implementing, and maintaining an Individualized Service Plan (ISP) with and for a person with developmental disabilities or Intellectual Disability	Please contact the individual agency availability and the area of LI they serve
□	Community Habilitation	The Community Habilitation service is intended to be a more efficient mechanism for the delivery of habilitative services in the community (i.e. non-certified settings) to facilitate community inclusion, integration, and relationship building.	Please contact the individual agency for availability
□	Residential Services	**1. Intermediate Care Facility for the Developmentally Disabled (ICF)** Certified by OMRDD. Funded through Medicaid. Provides room and board, 24- hour supervision and active programming, including training in activities of Daily Living (toileting, bathing, dressing, and grooming), socialization training and independent living skills. Specialized Intermediate Care Facility's (ICF) serve individuals with a variety of behavioral and/or medical needs. **2. Individual Residential Alternative (IRA)** Certified by OMRDD. Funded through Medicaid (Home and Community Based Services Waiver). Provides room and board. Supervision and programming determined by individual need. IRA's serve a variety of behavioral, medical or supervisory needs. **3. Supervised Community Residence (CR)** Certified by OMRDD. Funded by Supplemental Security Income (SSI) and New York State. Program provides on-site supervision and clinical supportive services primarily for individuals who need some training and experience in activities of daily living, socialization, and independent living, but who require 24 hour supervision. This category includes any programs that are termed supervised apartments. **3a: Supportive/Supervised Apartment** Certified by OMRDD. Funded by Supplemental Security Income (SSI) and N.Y.S. House or apartment providing an environment that fosters independent living with minimal supervision. Program includes socialization, supported or sheltered work and travel training. Supervision is limited. **4. Family Care (FC)** Certified by OMRDD. Funded by Supplemental Security Income (SSI) and N.Y.S. Certified Family Care homes provide a structured and stable home environment, and creates an atmosphere of family living, including the support, guidance and companionship found within a family unit. The responsibility for ensuring treatment and support services remains with the agency. **5. Individualized Support Services (ISS)** Funded by New York State. Provides funding to eligible consumers to assist these individuals to live independently in the community. An individualized support services grant supplements such expenses as room, board, and other support services.	Please see the LIFSSAC provider list at http://www.lifssac.com/9.html for list of agencies that offer residential services.

Name Date

Please select programs of interest			
Program		**Description**	**Area Served/Age Served**
□	Day Programs	**1. Day Habilitation (Day Hab.)** Day hab services are aimed primarily at developing those activities & skills outside of a person's home that assist him/her in developing a full life in his/her community. The services help an individual become a contributing member of his/her community as well as develop satisfying & rewarding connections & relationships in the community. These services are very flexible & can be provided almost anywhere in the community where an individual wishes to learn new skills. **2. Prevocational Services (Prevoc.)** Prevoc. Services are aimed at preparing an individual for paid employment. Prevocational services teach such concepts as following directions, attending to task, task completion, problem solving, and safety. Basic understanding of job performance requirements is also important aspect of prevocational services. The purpose of the service is habilitation rather than teaching a specific job skill. **3. Day Treatment (DT)** DT is a planned combination of diagnostic, treatment, & habilitation services provided to persons with developmental disabilities in need of a broad range of clinically supported & structures habilitation services. Regulatory changes have been made to foster person centered planning & community inclusion 4**. Sheltered Workshops/Work Centers** Sheltered workshops/work centers provide paid work to people with disabilities in a controlled and protective work environment. Attendees are considered "client workers" rather than employees of the workshop.	Please see the LIFSSAC provider list at http://www.lifssac.com/9.html for list of agencies that offer Day Services.
□	Employment	**Supported Employment** Supported employment is paid competitive work performed by individuals with severe disabilities who require support services to obtain & sustain employment. It is performed in an integrated setting which provides regular interactions with individuals who do not have disabilities and are not paid caregivers.	
□	Self Determination	Self-Determination provides people with developmental disabilities the opportunity - with the help of a "Circle of Support", to have the freedom to do the following: 1. The freedom to develop a personal life plan. 2. The authority to control a targeted amount of resources. 3. The support needed to obtain personal goals. 4. The responsibility for contributing to one's community and using public dollars wisely.	
□	IBS (intensive behavioral Supports)	IB Services are for individuals who live in non-certified settings or Family Care Homes and who present with substantial challenging behaviors that put them at imminent risk of placement into a more restrictive living environment.	