Application For Services

P.O. Box 2, 630 Rt 217, Mellenville, NY 12544
www.coarc.org (518) 672-4451

Application Date: _____

APPLICANT DATA

Name: _____ **DOB:** _____ **Gender:** _____

Address: _____ **Marital Status:** _____ **# Children:** _____

_____ **SS#:** _____

_____ **Medicaid #:** _____

County of Residence: _____ **Medicare #:** _____

Phone #: _____ **Private Insurance:** _____

Email: _____ Policy #: _____

TABS ID: _____

CONTACT INFORMATION

Primary Contact: *Self, Parent, Guardian or Caregiver*

Name: _____ **Primary Phone:** _____

Relation: _____ **Alternate Phone:** _____

Address: _____

Email: _____

Is this the legal guardian? Yes No **If yes, attach a copy of court document.**

Secondary Contact:

Name: _____ **Primary Phone:** _____

Relation: _____ **Alternate Phone:** _____

Address: _____

REFERRAL SOURCE

Agency: _____ **Phone #:** _____

Contact: _____ **Title:** _____

Address: _____

Email: _____

REFERRAL INFORMATION

Programs or Services: *Check all that apply.*

- ☐ **Employment Supports**
- ☐ **Service Coordination**
- ☐ **Adult Day Services**
- ☐ **Residential Services**
- ☐ **Community Prevoc**
- ☐ **Self-Directed Supports**
- ☐ **Weekend/Overnight Respite**
- ☐ **TBI At-Home Services**
- ☐ **Respite/Commnuity Habilitation**

Other: _____

Time Frame for Services: _____

Is the applicant ageing-out of school? Yes No

***If yes,* is the school a Residential School?** Yes No

Is there a legal guardian for the applicant? Yes No **If yes, attach a copy of court document.**

Has the person received services from COARC in the past? Yes No

Has a DDP4 been submitted showing a need for this service? Yes No

If yes, by which agency? _____

Other Information: _____

_____

_____

ELIGIBILITY & FUNDING

Funding Sources: *Please provide documentation.*

- ☐ **OPWDD**
- ☐ **HCBS Waiver**
- ☐ **Self-Directed**
- ☐ **OMH**
- ☐ **TBI**
- ☐ **ACCES-VR**
- ☐ **Aging-out Funds**
- ☐ **Private Pay**
- ☐ **School District (contract necessary)**

Case Manager or Service Coordinator: _____

Agency: _____ **Phone #:** _____

PHYSICIANS

Primary Physician:

Name: _____ **Phone #:** _____

Address: _____

Other Specialists:

Name: _____ **Phone #:** _____

Address: _____

Name: _____ **Phone #:** _____

Address: _____

MEDICAL INFORMATION

Developmental Disability/Diagnosis: _____

Medical Diagnosis: _____

Psychiatric Diagnosis: _____

Hospitalizations: *Medical, rehabilitation and/or psychiatric.* *Attach additional pages if necessary.*

Facility: _____ **Date:** _____

Facility: _____ **Date:** _____

Medications: *Attach additional pages if necessary.*

Name: _____ **Reason for medication:** _____

Name: _____ **Reason for medication:** _____

Name: _____ **Reason for medication:** _____

Medical Treatments: *G-tube feeding, chemotherapy, kidney dialysis, etc.*

_____

Allergies: *Food, medication, environmental, seasonal, etc.*

_____

Diet: *Specialized diet, restrictions, consistency, etc.*

_____

Vaccinations: *Please list dates.*

Tetanus: _____ **TB Screening:** _____

PPD: _____ **Hep B Series:** _____

Note: a current PPD is required for most programs PRIOR to admission.

Hearing Deficit: Yes No **Describe:** _____

Visual Deficit: Yes No **Describe:** _____

Walking Ability: *Please check appropriate response(s).*

- ☐ **Walks independently**
- ☐ **Walks with assistance from caregiver** Describe: _____
- ☐ **Walks with difficulty** Describe: _____
- ☐ **Walks with adaptive device** Describe: _____
- ☐ **Can climb stairs**
- ☐ **Cannot walk**

Does applicant use a wheelchair? Yes No **If yes, please check the appropriate response**

- ☐ **Can use wheelchair independently, including transfer**
- ☐ **Can use wheelchair independently with assistance in transfer**
- ☐ **Requires assistance moving and in transfer**

Other Information: _____

EDUCATIONAL/VOCATIONAL HISTORY

Does the applicant have an open ACCES-VR case? Yes No

If yes, name of counselor: _____

History: *Please list most recent first.*

Dates of Attendance	School, Program or Employer	Type of Class or Job Title

FUNCTIONAL SKILLS

Check all items the applicant is consistently able to accomplish.

Prevocational:
- ☐ Sort 3 different objects
- ☐ Completes 2-3 piece assembly
- ☐ Works for 10 minutes without prompting
- ☐ Works with another person on a 2 person task
- ☐ Asks for more materials when needed
- ☐ Notifies supervisor of personal needs

Money Skills:
- ☐ Counts and understands the concept of numbers
- ☐ Recognizes coins
- ☐ Knows coin values
- ☐ Makes change for 25¢
- ☐ Knows the value of money ($1, $5, $10, $20)

Orientation:
- ☐ Understands schedule, time of day for various activities
- ☐ Understands the different seasons
- ☐ Knows appropriate clothing based on weather
- ☐ Understands time; can read a clock
- ☐ Understands calendar (day, week, month)
- ☐ Understands holiday celebrations/activities

COMMUNICATION SKILLS

Primary Communication: *Please check appropriate response.*

☐ Verbal ☐ Communication Board
☐ Sign ☐ Gestures
☐ ASL ☐ Other Describe: _____

Primary Language: **Spoken** _____ **Understood** _____

Able to: ☐ Read ☐ Write

Articulation: ☐ Good ☐ Fair ☐ Poor

Most effective instructional method:

☐ Verbal Direction ☐ Signed Direction
☐ Modeling ☐ Co-Active (hand over hand)

Other Information: _____

INDEPENDENT LIVING SKILLS

Overall Hygiene: ☐ **Good** ☐ **Fair** ☐ **Poor**

Emergency Skills: *Check all items the applicant is consistently able to accomplish.*

- ☐ **Recognizes fire alarm**
- ☐ **Self preserving (knows to exit building less than 3 min.)**
- ☐ **Communicates name and address if lost**
- ☐ **Seeks appropriate assistance when lost**
- ☐ **Able to access 911 at appropriate times**

Domestic Tasks: Indicate level of ability by number.
(1) Independent **(2)** Capable with assistance/oversight/verbal prompts **(3)** Not able at this time

☐ **Set table**	☐ **Sort Laundry**	☐ **Wash Dishes**
☐ **Clear table**	☐ **Use washer**	☐ **Make Bed**
☐ **Store Food**	☐ **Use dryer**	☐ **Shop**
☐ **Cook**	☐ **Vacuum**	
☐ **Use Microwave**	☐ **Dust**	

Personal Hygiene: Indicate level of ability by number.
(1) Independent **(2)** Capable with assistance/oversight/verbal prompts **(3)** Not able at this time

☐ **Shower**	☐ **Bathe**	☐ **Use Feeding Tube**
☐ **Brush teeth**	☐ **Groom Hair**	☐ **Menstrual/Peri-Care**
☐ **Button**	☐ **Toilet**	☐ **Wash Hands**
☐ **Zipper**	☐ **Eat**	☐ **Use Catheter/Colostomy**
☐ **Snap**	☐ **Dress**	☐ **No assistance needed**

RECREATION AND LEISURE INFORMATION

What does the applicant enjoy doing in his or her spare time?

What activities does the applicant have an interest in doing or achieving (learning to cook, exercising, etc.)?

SUBSTANCE ABUSE HISTORY

Are there or have there ever been any concerns with substance abuse, including alcohol? Yes No

If Yes, please explain:

CRIMINAL JUSTICE HISTORY

Has the applicant ever been involved with the Criminal Justice System? Yes No

If Yes, please explain:

BEHAVIOR INFORMATION

				Comments or Causes
Aggression:	☐ Verbal	☐ Physical		
	☐ Never	☐ Occasionally	☐ Often	
	☐ Mild	☐ Moderate	☐ Severe	
Property Damage:	☐ Own	☐ Others		
	☐ Never	☐ Occasionally	☐ Often	
	☐ Mild	☐ Moderate	☐ Severe	
Injury to Self:	This includes but is not limited to eating inedible objects.			
	☐ Never	☐ Occasionally	☐ Often	
	☐ Mild	☐ Moderate	☐ Severe	
Supervision:	Refuses to follow direction, accept supervision or accept help.			
	☐ Never	☐ Occasionally	☐ Often	
	☐ Mild	☐ Moderate	☐ Severe	
Sexually inappropriate behaviors:				
	☐ Never	☐ Occasionally	☐ Often	
	☐ Mild	☐ Moderate	☐ Severe	
Runs or Wanders Away:				
	☐ Never	☐ Occasionally	☐ Often	
	☐ Mild	☐ Moderate	☐ Severe	
Takes other people's belongings:				
	☐ Never	☐ Occasionally	☐ Often	
	☐ Mild	☐ Moderate	☐ Severe	
Suicidal/Homicidal behavior:				
	☐ Never	☐ Occasionally	☐ Often	
	☐ Mild	☐ Moderate	☐ Severe	

What methods do you use to deal with the challenging behaviors the individual presents?

_____

_____

Please describe any strategies or reinforcements that may prevent behavioral episodes.

_____

_____

Please describe the applicants interactions in the community.

_____

Please describe the applicant interaction in a group setting.

_____

FINANCIAL INFORMATION

Applicant receives: *Check all that apply.*

☐	**Supplemental Security Income (SSI)**	
☐	**Social Security or Disability benefits (SSA, SSDI)**	
☐	**Benefits from a Special Needs Trust**	
☐	**Veteran, Railroad or Trust Fund benefits**	
☐	**Medicaid**	If yes, please include copy of card.
☐	**Medicare**	If yes, please include copy of card.
☐	**Private Insurance**	If yes, please complete the information below.

Private Insurance Information

Insurance Company _____

Policy Holder _____ Date of Birth _____

Policy Number _____ Group Number _____

OTHER

Is there any additional information you wish to share that is not included in this application?

_____

_____

_____

_____

_____

_____

_____

SIGNATURES

I HEREBY VERIFY THAT ALL THE ABOVE INFORMATION IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

Applicant Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____
(if applicable)

Person Completing Application: _____
(please print & sign)

Please retain a copy of this completed application for your own records.

ADDITIONAL INFORMATION

Please list any additional physicians, medications, behaviors, work history or educational history here. You may also use this page to document any additional information you believe will help us to make a more accurate assessment.

FOR OFFICE USE:

Date of Medicaid Eligibility Verification (MEVS):