



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.*

- Vocational Services
- Blended Day/Prevoc
- Adult Day Services
- Residential Services
- Service Coordination
- At-Home Residential Habilitation

- Day Respite
- Weekend/Overnight Respite
- Clinical Services
- TBI At-Home Services

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.*

- OMRDD
- HCBS Waiver
- NYS CARES

- OMH
- TBI
- VESID

- 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 VESID 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
- Sign
- ASL
- Communication Board
- Gestures
- Other Describe: _____

Primary Language: Spoken _____ Understood _____

Able to: Read Write

Articulation: Good Fair Poor

Most effective instructional method:

- Verbal Direction
- Modeling
- Signed Direction
- 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

- | | | |
|--|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Set table | <input type="checkbox"/> Sort Laundry | <input type="checkbox"/> Wash Dishes |
| <input type="checkbox"/> Clear table | <input type="checkbox"/> Use washer | <input type="checkbox"/> Make Bed |
| <input type="checkbox"/> Store Food | <input type="checkbox"/> Use dryer | <input type="checkbox"/> Shop |
| <input type="checkbox"/> Cook | <input type="checkbox"/> Vacuum | |
| <input type="checkbox"/> Use Microwave | <input type="checkbox"/> Dust | |

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

- | | | |
|--------------------------------------|-------------------------------------|---|
| <input type="checkbox"/> Shower | <input type="checkbox"/> Bathe | <input type="checkbox"/> Use Feeding Tube |
| <input type="checkbox"/> Brush teeth | <input type="checkbox"/> Groom Hair | <input type="checkbox"/> Menstrual/Peri-Care |
| <input type="checkbox"/> Button | <input type="checkbox"/> Toilet | <input type="checkbox"/> Wash Hands |
| <input type="checkbox"/> Zipper | <input type="checkbox"/> Eat | <input type="checkbox"/> Use Catheter/Colostomy |
| <input type="checkbox"/> Snap | <input type="checkbox"/> Dress | <input type="checkbox"/> 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

Aggression:

<input type="checkbox"/>	Verbal
<input type="checkbox"/>	Never
<input type="checkbox"/>	Mild

<input type="checkbox"/>	Physical
<input type="checkbox"/>	Occasionally
<input type="checkbox"/>	Moderate

<input type="checkbox"/>	Often
<input type="checkbox"/>	Severe

Property Damage:

<input type="checkbox"/>	Own
<input type="checkbox"/>	Never
<input type="checkbox"/>	Mild

<input type="checkbox"/>	Others
<input type="checkbox"/>	Occasionally
<input type="checkbox"/>	Moderate

<input type="checkbox"/>	Often
<input type="checkbox"/>	Severe

Injury to Self:

This includes but is not limited to eating inedible objects.

<input type="checkbox"/>	Never
<input type="checkbox"/>	Mild

<input type="checkbox"/>	Occasionally
<input type="checkbox"/>	Moderate

<input type="checkbox"/>	Often
<input type="checkbox"/>	Severe

Supervision:

Refuses to follow direction, accept supervision or accept help.

<input type="checkbox"/>	Never
<input type="checkbox"/>	Mild

<input type="checkbox"/>	Occasionally
<input type="checkbox"/>	Moderate

<input type="checkbox"/>	Often
<input type="checkbox"/>	Severe

Sexually inappropriate behaviors:

<input type="checkbox"/>	Never
<input type="checkbox"/>	Mild

<input type="checkbox"/>	Occasionally
<input type="checkbox"/>	Moderate

<input type="checkbox"/>	Often
<input type="checkbox"/>	Severe

Runs or Wanders Away:

<input type="checkbox"/>	Never
<input type="checkbox"/>	Mild

<input type="checkbox"/>	Occasionally
<input type="checkbox"/>	Moderate

<input type="checkbox"/>	Often
<input type="checkbox"/>	Severe

Takes other people's belongings:

<input type="checkbox"/>	Never
<input type="checkbox"/>	Mild

<input type="checkbox"/>	Occasionally
<input type="checkbox"/>	Moderate

<input type="checkbox"/>	Often
<input type="checkbox"/>	Severe

Suicidal/Homicidal behavior:

<input type="checkbox"/>	Never
<input type="checkbox"/>	Mild

<input type="checkbox"/>	Occasionally
<input type="checkbox"/>	Moderate

<input type="checkbox"/>	Often
<input type="checkbox"/>	Severe

Comments or Causes

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.

