Universal Application
For Provider Agencies in the Capital District

Attachments to be submitted with the application

1. **Copy of a recent physical examination**

2. **Copy of recent psychological evaluation that clearly states disability**

   - **If the individual has developmental disabilities, must document onset of disability prior to the age of 22**
   - **Include adaptive behavior scale (usually done as part of the psychological evaluation)**

3. **Copy of Individualized Service Plan (ISP) or Comprehensive Social History**

4. **Copy of Program Plan (IEP, Day Services Plan, etc.) as Applicable**

5. **Copy of DDP-4 if available**

6. **Mail to:**

   Schoharie County ARC
   P.O. Box 307
   Schoharie, NY 12157

Universal Application
For Provider Agencies in the Capital District

Date Received:_____

SERVICES YOU ARE INTERESTED IN RECEIVING: (check all that apply)
[ ] Residential Services [ ] In-Home Services [ ] Respite [ ] Family Support Services
[ ] Recreation [ ] Service Coordination [ ] Day Services [ ] Supported Employment
[ ] Clinic Services [ ] Other (describe)

_____

What is your timeframe? _____

APPLICANT DATA:

Name: _____ Birth date:

Gender: Male Female (circle one)

Address _____ Marital Status:

_____

_____ U.S. Citizen? Yes No (Circle One)

_____ Soc. Sec. # _____

County of Residence:_____ Telephone # ( ) _____

Does applicant have dependent children? Yes No How many?: _____

CONTACT: (Parent, Guardian, Caregiver)

Name: _____ Relationship: _____

Address:_____

_____

_____

Telephone # (Day) ( ) _____ (Eve) ( ) _____

REFERRAL SOURCE:

Name of Agency or School: _____

Contact Person: (if different from above) _____

Address:_____ Phone # ( )_____

_____ _____

LEGAL GUARDIAN (COURT APPOINTED IF OVER 18):

Name: _____ Phone: ( ) _____

Address: _____

_____

MEDICAL INFORMATION:

Developmental Disability/ Diagnosis: _____

Medical Diagnosis: _____

Psychiatric Diagnosis: _____

History of Hospitalization (medical and /or psychiatric) _____

_____

MEDICATION(s):

Name: _____

Reason for Medication: _____

Name: _____

Reason for Medication: _____

Name: _____

Reason for Medication: _____

Ongoing Medical Treatments needed: (G-Tube feeding, Chemotherapy, Kidney Dialysis, etc.)

_____

_____

_____

Allergies: (food, medication, other): _____

Date of last Tetanus: _____ TB Status (last Screening): _____.

Please be aware that a current PPD or Mantoux, and a HEP B screen will be required for most programs prior to admission

Circle the response that best describes applicant's functioning in the following areas
(indicate the one that best applies)

1. Hearing deficit Yes No
2. Visual deficit Yes No
3. Walking ability
   a. Independent b. with difficulty c. Corrective device
   d. Assistance from caregiver e. Cannot walk

4. Can independently climb stairs Yes No

5. Does applicant use a wheelchair? Yes No

Mark the one response that best describes wheelchair (may be motorized) mobility:

1. Can use wheelchair independently, including transfer.
2. Can use wheelchair independently with assistance in transferring.
3. Requires assistance in transferring and moving.
4. No Mobility - Must be transferred and moved.

Comments: _____

_____

Describe any adaptive equipment used: _____

_____

PRIMARY PHYSICIAN:

Name: _____ Phone:( ) _____

Address:

_____

OTHER SPECIALISTS:

Name: Phone:( )

_____ _____

Address:

_____

Name: Phone:( )

_____ _____

Address:

EDUCATIONAL/ VOCATIONAL INFORMATION: (Begin with the most recent. List name of school/program or employment, type of class, dates of attendance, etc).

1. _____

_____

2. _____

_____

3.

_____

_____

Does the applicant have an open VESID case Yes No

Name of Counselor: _____.

COMMUNICATION SKILLS:

Verbal: _____ Describe level of ability: _____

Primary Language (Spoken) _____ (Understood) _____

Non-Verbal: _____ Uses Sign Language _____

Describe how much sign is used or other methods of communication:_____

_____

Additional Comments*:* _____

_____

DAILY LIVING SKILLS:

What assistance does the applicant need in the area of Toileting? _____

_____

What assistance does the applicant need for Eating / Drinking? _____

_____

What assistance does the applicant need to be safe in the home? _____

_____

What assistance does the applicant need to be safe in the community? _____

RECREATION/ LEISURE TIME ACTIVITIES:

1. What does the applicant enjoy doing in their spare time? _____

_____

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

_____

_____

BEHAVIORS: *For each, describe what causes the behavior, how often it happens, and how severe it is.*

1. Aggressive Behaviors (verbal/ physical) _____

_____

2. Damages own or others property _____

_____

3. Injury to self (include eating inedible objects) _____

_____

4. Refuses to follow direction or accept supervision or help: _____

_____

5. Sexually inappropriate behaviors: _____

_____

6. Runs or Wanders Away _____

_____

7. Takes belongings of others _____

_____

8. Other _____

_____

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

_____

_____

CRIMINAL JUSTICE

Has the applicant ever been involved with the criminal justice system? Yes No

If yes, Please explain _____

_____

FINANCIAL BENEFIT INFORMATION:

Applicant receives Supplemental Security Income (SSI) Yes No

Applicant receives Social Security or Disability Benefits (SSA, SSDI) Yes No

Applicant currently receives Medicaid Yes No

Medicaid# _____ County: _____

Applicant currently receives Medicare Yes No

Medicare #: _____

Applicant is covered under Other Health Insurance Yes No

Insurance Company _____

Policy Holder _____ Date of Birth _____

Policy Number: _____ Group Number _____

Applicant receives Benefits/ Income not listed (Veteran's, Railroad, Trust Fund)

_____

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

_____

_____

_____

Are you currently receiving services from any other agency? Yes No
(Service Coordination, Residential Habilitation, Respite, etc)

Is the applicant HCBS Waiver enrolled? Yes No

Agency Name: _____

Type of Service: _____

Name of Contact: _____

Phone: ( ) _____ - _____

I hereby verify that all of the above information is correct and accurate to the best of my knowledge.

Applicant: _____ **Date:** _____

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

Person completing application: _____