

**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

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: _____