



Application Date: _____

Intake Application

Please check which waiver you are applying for and which services you are interested in receiving.

OPWDD/HCBS WAIVER

- | | |
|-------------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> Day Habilitation | <input type="checkbox"/> Residential |
| <input type="checkbox"/> Community Habilitation | <input type="checkbox"/> Respite – In-Home |
| <input type="checkbox"/> Respite – After School | |

1. Person's Information:

Person's Name: Last _____ First _____ MI _____
Date of Birth: Mo/Day/Year [____][____][____]
Sex: Male Female
Current Address: Street _____
City _____ State _____ Zip _____
Phone Number: (____) _____
Medicaid Number: _____
BC/CS Number: _____
Other Insurance: _____
Email Address: _____

2. In case of emergency, the following person(s) are to be called:

Name: Last _____ First _____ MI _____
Relationship: Parent Guardian Spouse Other _____
Current Address: Street _____
City _____ State _____ Zip _____
Home Phone: (____) _____ Cell:(____) _____ Work Phone: (____) _____
Email Address: _____

If unable to reach, call:

Name: Last _____ First _____ MI _____
Relationship: Parent Guardian Spouse Other _____
Current Address: Street _____
City _____ State _____ Zip _____
Home Phone: (____) _____ Cell:(____) _____ Work Phone: (____) _____
Email Address: _____

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3. Primary Language (communication skills)

- English
- Spanish
- American Sign Language
- Symbolic (type_____)
- Communication Device
(type_____)
- Non-verbal
- Other_____

Secondary Language (communication skills)

- English
- Spanish
- American Sign Language
- Symbolic (type_____)
- Communication Device
(type_____)
- Non-verbal
- Other_____

Communication Abilities:

- effectively communicates wants/needs
- can carry on a conversation
- utilizes alternative communication (specify):_____
- needs a translator (specify person/agency):_____
- needs prompting/cueing to initiate communication
- has difficulties with articulation/speech
- needs prompting/cueing to engage in conversation

4. Does person have a court appointed guardian or custodian? No Yes

If yes, Please list below and attach documentation:

Name: Last_____ First_____ M_____

Relationship: Parent Guardian Spouse Other_____

Current Address: Street_____

City_____ State_____ Zip_____

Home Phone: (____)_____ Cell:(____)_____ Work Phone: (____)_____

Email: _____

5. Primary Health Care Provider

Primary Physician: _____

Street_____

City_____ State_____ Zip_____

Office Phone: (____)_____ Fax:(____)_____

Hospital Affiliation: _____

6. Care Manager/Coordinator: _____

CCO Affiliation: _____

Street_____

City_____ State_____ Zip_____

Office Phone: (____)_____ Fax:(____)_____

Email: _____

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11. Describe person's disability history. Please include any special medical or mental health issues in the history.

(Please attach separate sheet if necessary. Please do not state "refer to..." another document.)

Height _____

Weight _____

Primary Diagnosis _____

Secondary Diagnosis _____

Comprehension Ability:

comprehends verbal directions without problems

understands simple directions

does not understand simple directions

understands Sign Language

other, please describe: _____

12. Does person have a history of behavioral challenges or current behavior plan?

No Yes If yes, please complete the following:

a. Will this plan need to be utilized while the person is receiving services?

No Yes If yes, please attach the plan, a consent and addendum stating that the plan applies to the service person will be receiving at EPI.

b. What specific behaviors does the plan address? (ex: Biting, aggression, PICA, SIB)

c. What triggers these behaviors?

d. How long has the plan been in place?

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13. School/Program Information:

Is person attending school or a day program? No Yes If yes, please list below:

School or Program Name: _____

Contact Name: Last _____ First _____

Address: Street _____

City _____ State _____ Zip _____

Contact Phone Number: (____) _____ Work Phone: (____) _____

Transportation Provider: _____

Transportation Contact: Last _____ First _____

Contact Phone Number: (____) _____

14. Has person ever had a seizure? No Yes If yes, please answer the following:

a. When was the last time person had a seizure? _____

b. How often does person have a seizure? _____

c. Please describe, as fully as possible, a typical seizure episode, including physical characteristics and duration. Describe any warning signs that a seizure is about to occur.

d. How often does person see the physician who treats their seizures? _____

e. Is person taking medication(s) to control their seizures? No Yes

f. If yes, what medication(s) is person taking to control their seizures? _____

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15. Cognitive Status: (please check all that apply)

Orientation: Oriented to: time place person activities day/week
 needs prompting/cueing for orientation
 easily confused not oriented

Attention/Concentration: able to stay on task independently easily distracted
 needs occasional verbal cues/prompts to stay on task
 requires constant cueing/prompting

Initiation: initiates activities requests assistance when needed ability varies for ADLs
 needs cues/prompts to initiate tasks/activities cannot initiate tasks/activities

Memory: memory is functional for day-to-day activities short term memory difficulties
 long term memory difficulties

Organization: good organizational skills ability varies based on task/activity
 needs prompting/cueing for organizational skills
 needs others to provide organization

Problem-Solving/Judgment: aware of current skills/limitations makes reasonable decisions
 needs cues/prompts for problem-solving
 unable to engage in problem-solving activities

Learning abilities: able to follow one-step directions able to follow multi-step directions
 interested in and willing to learn new strategies/tools
 not able to follow directions

Other details regarding cognitive status:

16. Social and Recreational Activities

a. Describe how person interacts with peers, younger children, and authority figures.

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b. Describe person's favorite activities/hobbies? What supports or supervision are needed to participate in these activities?

c. Are there any special concerns when person is in the community (on an outing for example). What supports or supervision are needed to participate in these activities?

d. Does person have any special travel needs such as a wheel chair, person to accompany them, special accommodations, or supervision? What supports or supervision are needed to participate in these activities?

e. Does person need transportation to get to and from services? No, Yes If yes, please describe.

f. Does person have the ability to understand and handle money?

Handling limit_____

17. Dietary Regulations: (check all that apply)

- | | | | |
|------------------------------------------------------------------------------------|--------------------------------------------------|---------------------------------------------|------------------------------------------|
| <input type="checkbox"/> Heart Healthy (Regular) | <input type="checkbox"/> Low Sodium | <input type="checkbox"/> Low Fat | <input type="checkbox"/> Low Cholesterol |
| <input type="checkbox"/> Diabetic Diet | <input type="checkbox"/> Renal Diet | <input type="checkbox"/> Cardiac Diet | |
| <input type="checkbox"/> Nutritional Supplement | <input type="checkbox"/> Swallowing Difficulties | <input type="checkbox"/> Tube Feeding | |
| <input type="checkbox"/> Pureed Foods | <input type="checkbox"/> Ground Consistency | | |
| <input type="checkbox"/> Chopped Consistency | <input type="checkbox"/> Thickened Liquids | <input type="checkbox"/> Adaptive equipment | |
| <input type="checkbox"/> Aspiration Precautions (if checked please explain): _____ | | | |

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Dentures: Upper Lower Partial

Special Dietary Considerations (e.g. vegetarian, kosher, etc.) specify:

Describe any specific information that pertains to person's ability to eat and drink:

18. Mobility:

Mode of Ambulation: independent cane walker
 wheelchair scooter unable

Ability to Ambulate: independent needs periodic supervision/oversight
 needs ongoing supervision/oversight
 one person assist two-person assist unable

Ability to Transfer: independent needs periodic supervision/oversight
 needs ongoing supervision/oversight
 one person assist two-person assist unable
 mechanical lift other

20. What is person's evacuation capability? Is person able to safely evacuate any structure by themselves? No Yes If no, what type of support/assistance is needed?

21. ADLS/IADLS:

Basic ADLs (Eating, Dressing, Toileting, etc.):

independent needs verbal cues/prompts needs physical cues/prompts
 needs hands-on assistance needs total support

Is person continent of bowel? No Yes

Is person continent of bladder? No Yes

If *No* to either question, please describe toileting needs and routines, including the use of adult continence products.

Will person ask for toileting assistance? No Yes

Will person be aware if he or she is incontinent? No Yes

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Household Activities (Meal Prep, Laundry, etc.):

- independent needs verbal cues/prompts needs physical cues/prompts
 needs hands-on assistance needs total support

IADLs (Shopping, Banking, etc.):

- independent needs verbal cues/prompts needs physical cues/prompts
 needs hands-on assistance needs total support

Endurance/Strength:

- able to engage in routine activities experiences periodic fatigue fatigues easily
 requires frequent rest periods needs physical assistance to engage in routine activities

22. Durable Medical Equipment:

Supply or Equipment Item	Purpose of Equipment	Prescribed By and Phone Number

23. Hearing Ability: Hears adequately Hearing difficulty Uses Hearing Aid

Hearing Impairment Effects: Right Ear Left Ear Other devices used:

Describe any specific information that pertains to person's ability to hear:

24. Visual Ability: Vision is adequate for daily activities

- Visually Impaired Right Eye Left Eye Wears Glasses Needs Large Print
 Cataracts Right Eye Left Eye
 Blind Right Eye Left Eye Uses Braille
 Eye Prosthesis Right Eye Left Eye
 Guide Dog
 Other: _____

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Describe any specific information that pertains to person's vision:

25. Medication Regimen

Please list all current medications.

Medications (prescription and over-the-counter)	Dosage	Route (injection, oral, etc.)	Frequency	Purpose	Prescribing MD

26. Special Needs for Medications.

- a. Does person have any special needs to enable them to take medication, such as taking the medication in pudding, applesauce, etc? This may be such things as taking the medication with a special food, with a special cup or spoon, or in a special way.

No Yes If yes, please describe those special needs.
