EPILEPSY PRALID INC

# Intake Application

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

☐ **OPWDD/HCBS WAIVER**
- ☐ Day Habilitation
- ☐ Medicaid Service Coordination
- ☐ Residential
- ☐ Community Habilitation

☐ **TRAUMATIC BRAIN INJURY WAIVER**
- ☐ Service Coordination
- ☐ Structured Day Program
- ☐ Environmental Modification (E-mod)
- ☐ Home and Community Support Services (HCSS)
- ☐ Community Integration Counseling (CIC)
- ☐ Independent Living Skills (ILST)

☐ **NURSING HOME TRANSITION AND DIVERSION WAIVER**
- ☐ Service Coordination
- ☐ Structured Day Program
- ☐ Environmental Modification (E-mod)
- ☐ Moving Assistance
- ☐ Wellness Counseling
- ☐ Community Integration Counseling (CIC)
- ☐ Independent Living Skills (ILST)
- ☐ Community Transitional Services (CTS)
- ☐ Respite
- ☐ Home and Community Support Services (HCSS)

**1. Applicant Information:**

Consumer Name: Last_____First_____MI_____
Date of Birth: Mo/Day/Year [_____][_____][_____]
Sex: ☐ Male ☐ Female
Social Security Number: [_____]-[_____]-[_____]
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: _____

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 this applicant 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. **Name, Service Coordinator:** _____
   Agency Affiliation: _____
   Street _____
   City _____ State _____ Zip_____
   Office Phone: (____)_____ Fax:(____) _____
   Email: _____

7. **Does this applicant have any known allergies, for example, to foods, medications, or the environment?** ☐No, ☐Yes. If yes, please list below:

   _____

_____

_____

8. **Has this applicant ever been convicted of a felony?** ☐ No, ☐ Yes. If yes, please list below:

_____

_____

_____

The applicant is currently on ☐ probation ☐ parole for the following charge:
List any specific conditions of parole/probation: _____

_____

_____

Probation/parole is expected to end on: _____

9. **Does the applicant have a DNR order?** ☐ No, ☐ Yes. If yes, attach a copy to this form.

**Does the applicant have a Health Care Proxy?** ☐ No, ☐ Yes. If yes, attach a copy to this form.
**Name of Health Care Proxy:** _____
**Name of Alternate Health Care Proxy:** _____

**Does the applicant have a Living Will?** ☐ No, ☐ Yes. If yes, attach a copy to this form.

**Does this applicant have a Power of Attorney?** ☐ No, ☐ Yes. If yes, attach a copy to this form.
**Name of Power of Attorney**: _____

10. **Describe the reason(s) this applicant is requesting services from Epilepsy-Pralid, Inc.**
(Please attach separate sheet if necessary. Please do not state "refer to …" another document.)

_____

_____

_____

_____

11. **Describe this applicant'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 the applicant 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 consumer is receiving services?
☐ No, ☐ Yes If yes, please attach the plan, a consent and addendum stating that the plan applies to the service the consumer will be receiving at Epilepsy-Pralid, Inc.

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?

**13. School/Program Information:**
Is the applicant 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 this applicant ever had a seizure?**. ☐ No, ☐ Yes If yes, please answer the following:
a. When was the last time the applicant had a seizure? _____
_____

b. How often does the applicant 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 the applicant see the physician who treats their seizures? _____

_____

e. Is the applicant taking medication(s) to control their seizures? ☐ No, ☐ Yes

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

_____

**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 the applicant interacts with peers, younger children, and authority figures.

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

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

d. Does the applicant 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 the applicant need transportation to get to and from services? ☐ No, ☐ Yes If yes, please describe.

f. Does the applicant have the ability to understand and handle money?
Handling limit_____

**17. Dietary Regulations: (check all that apply)**

| | | | |
|---|---|---|---|
| ☐ Regular | ☐ Low Sodium | ☐ Low Fat | ☐ Low Cholesterol |
| ☐ Diabetic Diet | ☐ Renal Diet | ☐ Cardiac Diet | ☐ Nutritional Supplement |
| ☐ Swallowing Difficulties | | ☐ Pureed Foods | ☐ Ground Consistency |
| ☐ Chopped Consistency | ☐ Thickened Liquids | ☐ Tube Feeding | ☐ Adaptive equipment |

☐ Aspiration Precautions (if checked please explain): _____

_____

_____

☐ Dentures: ☐ Upper ☐ Lower ☐ Partial

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

Describe any specific information that pertains to the applicant'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 the applicant's evacuation capability?** Is the applicant 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 this applicant continent of bowel?** ☐ No, ☐ Yes
**Is this applicant continent of bladder?** ☐ No, ☐ Yes

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

**Will the applicant ask for toileting assistance?** ☐ No, ☐ Yes
**Will the applicant be aware if he or she is incontinent?** ☐ No, ☐ Yes

**Household Activities (Meal Prep, Laundry, etc.):** ☐ independent ☐ needs verbal cues/prompts ☐ needs physical cues/prompts ☐ needs hands-on assistance ☐ must be completed by others

**IADLs (Shopping, Banking, etc.):** ☐ independent ☐ needs verbal cues/prompts ☐ needs physical cues/prompts ☐ needs hands-on assistance ☐ must be completed by others

**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 the applicant'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: _____

Describe any specific information that pertains to the applicant'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 this applicant 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.
_____
_____
_____

b. Is this applicant capable of self medication administration? ☐ No, ☐ Yes. If yes, please describe any special needs and supports needs by this applicant for self medication administration.
_____
_____
_____

# Physicians:

Neurologist

Dr._____ _____ _____
First MI Last

_____
Office Address

_____ _____ _____ _____
City State Zip Office Phone

Other Physician: Discipline: _____

Dr._____ _____ _____
First MI Last

_____
Office Address

_____ _____ _____ _____
City State Zip Office Phone

Other Physician: Discipline: _____

Dr._____ _____ _____
First MI Last

_____
Office Address

_____ _____ _____ _____
City State Zip Office Phone

Other Physician: Discipline: _____

Dr._____ _____ _____
First MI Last

_____
Office Address

_____ _____ _____ _____
City State Zip Office Phone

**Thank you for completing this form.**

Print Name of Person completing this form_____

Relationship to Applicant_____

Signature of person completing form_____

Phone Number (____)_____

Email Address: _____

**Once completed please forward to:**
**Intake Department**
**Epilepsy-Pralid, Inc.**
**1650 South Ave., Suite 300**
**Rochester, NY 14620**
**(585) 442-4430**
**Fax: (585) 442-6305**