EPILEPSY PRALID INC

Application Date: _____

Intake Application

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

☐ **OPWDD/HCBS WAIVER**
- ☐ Day Habilitation
- ☐ Community Habilitation
- ☐ Respite – After School
- ☐ Residential
- ☐ Respite – In-Home

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

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

1. Person's Information:

Person's 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 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: _____

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

_____
_____
_____

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

_____
_____
_____

The person 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 person have a DNR order?** ☐ No, ☐ Yes. If yes, attach a copy to this form.

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

Does person 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) person is requesting services from Epilepsy-Pralid, Inc.**
(Please attach separate sheet if necessary. Please do not state "refer to …" another document.)

_____
_____
_____
_____

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 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 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? _____

_____

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.
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)

☐ Heart Healthy (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 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'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

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 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: _____

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.
_____
_____
_____

b. Is person 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 person applying_____

Signature of person completing form_____

Phone Number (____)_____

Email Address: _____

Once completed please forward via one of the methods below:

By Mail
Attn: Intake Department
Epilepsy-Pralid, Inc.
1650 South Ave., Suite 300
Rochester, NY 14620

By SECURE/ENCRYPTED email
intake@epiny.org

By Fax
(not suggested for larger 50+ pages)
Fax: (585) 442-6305

For Questions/other documents
(585) 442-4430 x2724