EMPOWERING PEOPLE'S INDEPENDENCE

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 EPI.**
(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 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?

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: ____________________________________

EPI
Intake Application

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

EPI
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) 486-1497.

For any questions
(585) 442-4430 x2724