We are pleased that you are considering EEDA programs for yourself, a loved one, or a person for whom you advocate. In order to expedite the intake process it is imperative that the application is completed in its entirety. We also ask that the required documents are attached as part of the application packet. Your application for services cannot be processed without the requested information provided.

Thank You,

Joan Lucarelli
Admissions Coordinator
631 369-7345 Ext. 125

If you need assistance filling out this application please contact your MSC or the LIDDSO Intake Unit (631-434-6000)

APPLICANT'S INFORMATION

Name: ____ Date: ______________________

Current Address: ____

Home Phone: _____________________________ Cell Phone: _____________________________

Date of Birth: ______________________ Birthplace:_______________________________________

Tabs ID # (if known) ________________________ Email : __________________________________

OPWDD Eligibility Yes/No If yes as of what date____

Does applicant have a Medicaid Service Coordinator□ Yes □ No

Agency Name: ____

Name of Medicaid Service Coordinator: __________________________ Phone: _________________

Is the applicant enrolled in the HCBS Waiver□ YES □ NO Enrollment Date:______________________

Name Date

DISABILITIES

(*Please check all that apply*)

______Age of Onset of Primary Disability

__Intellectual Disabilities (ID) (Formerly MR) __Epilepsy/Seizure Disorder __Autism

__Asperger's Syndrome __Cerebral Palsy __Familial Dysautonomia

__Down's Syndrome __Learning Disability __Sensory Impairment

_Physical/Medical Condition __Psychiatric Disability *(Secondary to Dev. Dis.)* __Traumatic Brain Injury *(Prior to age 22)*

_Tourette syndrome __Spina Bifida __Prader Willi

__Other Neurological Impairment (Please explain :____)

COGNITIVE ABILITY

Verbal I.Q.________ Performance I.Q.________ Full Scale I.Q.___________________

Vineland II Adaptive Score_______________ ID Level: ______________________

BENEFIT INFORMATION

US Citizen or National: Yes or No Lawful Permanent Resident #: **A**__________________

Social Security #____________________

Is the applicant covered by Medicaid □Yes □ No

If YES: Medicaid Identification Number (CIN)_______________ Date Approved:______________

HMO Plan (if applicable)____

If NO: Was a Medicaid application filed? □Yes □ No If YES, complete the following:

Date of application: ______________________Date of denial: ____________________

Reason for denial: ____

Medicare #__________________________Parts A/B/D Part D Drug Plan: ___________________

Primary Insurance:___________________Policy Holder:___________________________________

Policy #_________________________________Group #___________________________________

SSI Benefits: Yes / No SSD Benefits: Yes /No Supplemental Needs Trust (SNT): Yes/No

Representative Payee for Benefits:

Name: ____

Address:____Phone_________________

Name Date

Is the applicant Employed Yes/No: If Yes: Where____

PARENT / GUARDIAN / CAREGIVER INFORMATION

Mother	Father
Name:_______________________________________	____
Address:_____________________________________	____
____	____
Home Phone: _____________________________	____
Work Phone:_________________________________	____
Cell Phone:_________________________________	____
E-Mail: ____________________________________	____

Court Appointed Guardian? Yes /No If Yes relationship: ______________________________________
If Yes: Date in which court?

If there is a court appointed guardian(s), please provide a copy of the guardianship papers.

Siblings

Name:________________________________ Age:_________ Reside at Home:___

Name:________________________________ Age:________ Reside at Home:___

Other Household Members / Other Primary Care Giver

Name: ____________________________________ Relationship to applicant: ____________________

APPLICANT'S CURRENT DAY ACTIVITY (check all that apply)		
□ School (graduation year____) School Name ______________ Tel # ____________________ Financially responsible school district Name:_________________ Tel #: ______________________	□Day Program Program Name: _____________ Tel # ______________________ Days Scheduled: ________________	□ Place of Employment Employer __________________ Tel # ______________________ Days Scheduled: _______________

Home #: ___________________Work #: _________________________ Cell #: __________________

Name Date

Who of the above is the primary contact person and when is the best time to call? ________________
____

Emergency Contact Details:

Name: ___________________________ Relationship: _____________________Phone #: ________

Name: ___________________________ Relationship: _____________________Phone #: _________

PERSONAL INFORMATION

Gender: Male ◻ Female ◻ Height: _____ Weight: ____ Hair Color: ______ Eye Color: ________

Identifying Marks or Features: ____

Ethnicity/Race: check all that apply - Answers to these questions will not affect eligibility for services

◻ White	◻ Asian or Pacific Islander
◻ African American	◻ American Indian/Alaskan
◻ Hispanic	◻ Other
Religion:	

SENSORY SKILLS

Which best describes the applicant's hearing?	◻ Normal ◻ Mild/Moderate ◻ Severe/Profound loss ◻ Sensitivity to Noise
Does the applicant use a hearing aid?	◻ Yes ◻ No
Which best describes the applicant's vision?	◻ Fully sighted ◻ Moderate impairment ◻ Severe impairment ◻ Blind
Does the applicant use glasses?	◻ Yes ◻ No

COMMUNICATION

Check the responses that best describes the applicants method of communication

◻ Verbal	◻ Uses signs or communication device
◻ Uses gestures, vocalizations	◻ Unable to communicate

AMBULATION

______Walks Independently ______Unsteady Gait ______Walks with Physical Assistance

______Requires Use of Wheelchair _______Uses Other Adaptive Equipment to Ambulate *(If yes, please describe)* ____

ABILITIES AND STRENGTHS

Socialization: Indicate accordingly: 1. Never 2. Sometimes 3. Often 4. Always

___ Interacts with others	___ Displays affection appropriately
___ Maintains friendships	___ Greets appropriately
___ Occupies self independently	___ Is Cooperative

Name Date

___ Initiates conversation	___ Accepts limitations
	___ Controls temper
Please include any other special socialization information that you consider important for the staff to be aware of. ____ ____	

SELF CARE

Indicate accordingly: 1. Independent 2. Needs supervision 3. Needs assistance 4. Completely dependent

___ Eating	___ Dressing
___ Toileting	___ Bathing / shower
___ Tooth brushing	___ Shaving
___ Menses	___ Administering medications
Please include any other special self care information that you consider important for the program staff to be aware of? ____ ____	

BEHAVIOR PROFILE

(Please indicate frequency)

0=Never 1=Daily 2=Weekly 3=Monthly 4=Every 3 Months 5=Every 6 Months

	No Problems		Physically Assaultive		Pica
	Self-Injurious		Withdrawn		Fire Setting
	Sleeping Disorders		Eating Disorder		Stealing
	Verbally Abusive		Sexual Misconduct		Smears Feces
	Temper Tantrums		Alcohol/Substance Abuse		Elopement
	Destroys Property		False Statements		Teasing
	Enuresis		Mood Changes		Hyperactive
	Impulsive		Non-Compliance		Wanders

COMMENTS: Please indicate other pertinent information related to unusual or maladaptive behaviors and/or psychiatric symptoms (i.e., how often do behaviors/symptoms occur?)

____

____

____

____

Name Date

MEDICAL HISTORY

Medical needs: Please list any medical conditions or needs that may impact the individuals, such as seizures or diabetes, etc.

____

____

____

____

Allergies:

Medication Allergies: ______________________________ Reaction: _____________________

Food Allergies: ___________________________________ Reaction: ______________________

Environmental Allergies: ___________________________ Reaction: _____________________

Other: Tuberculosis- Mantoux /TB/PPD skin test

- Reason for a Mantoux test:
  - New York State Health Department mandates this test to control and eradicate TB
- If the test results are Negative:
  - *As per the June 2010 regulation two negative PPD's are required. The first negative followed in 1-3 weeks by the second. If both negative this is documented & an annual screening by a health care provider is appropriate.*
- If the test results are positive:
  - If there is a positive PPD result, a chest x-ray (within two years) and a note from the doctor, within a year, stating the individual is clear of communicable diseases is required.
- If the family refused the PPD testing:
  - A note from the doctor, within a year, that the individual is clear of communicable diseases is required.

DOCUMENTATION MUST BE ATTACHED

NUTRITION

Please indicate if there are any special dietary requirements or any food restrictions.

____

____

____

____

Name Date

MEDICAL / DENTAL PROVIDERS

Physician's Name:____

Address: ____

Phone: ____

Dentist's Name: ____

Address: ____

Phone: ____

Psychiatrist's Name:____

Address: ____

Phone: ____

Specialist's Name:____

Specialty: ____

Address: ____

Phone: ____

Specialist's Name:____

Specialty: ____

Address: ____

Phone: ____

Other Providers: ____

Address: ____

Phone: ____

Name Date

CURRENT MEDICATIONS

Medication	**Dose** (amt/frequency/time)	**Prescribed By**	**Diagnosis**

Please attached additional sheets if needed

DOCUMENTATION

Please be sure to attach copies of the documents indicated below. All information must be within the last 1 (one) year unless otherwise noted.

The following documents are required as part of the Universal Application

Required Document	**Document attached √**	**Date of document**
Annual Physical Exam		
Immunization (PPD info on page 6)		
Psychological Evaluation (Must be within 3 years)		
Adaptive Behavior Scale, ie., Vineland, ABAS, etc (Must be within 3 years) .		
Psycho-Social Evaluation (Must be within 3 years)		
***If you are applying for a HCBS Waiver program you MUST include the ISP**		
Level of Care Eligibility Determination (LCED) (if waiver enrolled)		
Notice of Decision (NOD) (if waiver enrolled)		
Copy of Medicaid Card (if applicable)		
OPWDD Eligibility Determination		
Privacy Practices Sign Off		
Signed consent for release of information		

Signatures:

By signing below you agree that this application MAY be used to apply to all agencies in the Long Island DDSO; You also understand that additional paperwork may be needed for individual agencies and programs.

By signing below I confirm that the information provided in this application is complete and accurate to the best of my knowledge.

I understand that failure to provide comprehensive and accurate information may result in the applicant's non-acceptance into an agency's program.

Applicant: ____ _Date:_______________

Parent/Advocate/Guardian: ____Date_______________

Person completing application_____________________________ _______Date_______________

Referred by: ____ ______Phone______________

Name Date

Please select programs of interest			
Program		**Description**	**Area Served/Age Served**
☐	Family Support Services (FSS)	LIFSSAC web site: http://www.lifssac.com/ LIFSSAC Grant List: http://www.lifssac.com/3.html Support services offered to developmentally disabled individuals that are living at home with their families. These services include: in home and out of home respite, recreational programs, crisis intervention, advocacy, sibling support, outreach, and resources. ***See description below of services but please note not every agency offers all services please contact the individual agency to ascertain what they offer.***	Please contact the individual agency to find out what FSS services they offer and what area of LI they serve.

Please select programs of interest			
Program		**Description**	**Area Served/Age Served**
☐	Family Reimbursement Program	Provides resources to obtain respite care. Funds can be utilized for expenses that are not covered by Medicaid or insurance.	East of William Floyd Parkway/Ages 3 and up
☐	Day Habilitation	On a daily basis, EEDA's consumers and staff participate in various trips that allow them to become more active members of the community. Riverhead and Calverton locations.	East of William Floyd Parkway/Ages 18 and up
☐	Residential Living Options	Beautiful, safe homes and lives of distinction for the people we support in group homes and apartments.	East of the William Floyd Parkway/Ages 18 and up
☐	Service Coordination	Qualified Service Coordinators use a person centered approach to assist individuals to facilitate the process of achieving their life goals and accessing needed services to attain a full and balanced life.	East of William Floyd Parkway/Ages 8 and up
☐	Environmental Modifications	Adaptations to the home necessary to increase or maintain a person's ability to live at home with independence.	East of William Floyd Parkway/Ages 3 & up
☐	After School Therapeutic Recreation	Offers children the opportunity to participate in various activities including art, music, puzzle building, sports, and games. The goal is to enhance leisure activities.	East of William Floyd Parkway/Ages 5-22
☐	Overnight Respite	Provides professional supervision to loved ones in a safe environment so caregivers can have a scheduled break and program participants can socialize with peers.	Suffolk County/ Ages 7 and up
☐	Emergency Overnight Respite	A safe environment where up to four individuals in crisis can have a short term stay.	Suffolk County/Ages 7 and up
☐	Crisis Intervention Team	A crisis is an individualized need that varies from family to family. Situations can be as serious as the illness or death of a caregiver, support during medical appointments, or with behavioral challenges. Staff support and 24 hour hotline.	East of Route 112/Ages 7 and up
☐	Adult Socialization Program	A social environment to foster new and maintain old friendships. Designed to spark new recreation and leisure interests with peers.	East of William Floyd Parkway/Ages 18 and up
☐	School Vacation Program	Recreational program offered during most major school holidays and vacations.	East of William Floyd Parkway/ Ages 5-22
☐	Saturday Program	Provides children onsite recreational activities and offsite trips such as visits to local parks, playgrounds and activity centers, while providing a respite period for their families.	East of William Floyd Parkway/ Ages 5-22

Name Date

RELEASES

Medications I, the parent or legal guardian of _______________________________ (applicant's name), give my consent to allow the program coordinator to give medication as stated on a written doctors' order/prescription. An updated physicians prescription must be provided and maintained at the participants program. I further agree to supply enough medication in the original container for each day that the individual attends program. I understand that failure to submit a doctor's order will result in the individual not receiving medication during his/her time with us.

Parent or Guardian Signature ____ **Date** _____________________

Emergency Medical Treatment I, the parent or legal guardian of _______________________________________ (applicant's name), give my consent to allow E.E.D.A. to provide emergency medical treatment if needed. I understand that all effort will be made to reach me in the event of an medical emergency. In addition, my signature below indicates that I will not hold E.E.D.A. responsible for any liabilities resulting from participation in this program.

Parent or Guardian Signature ____ **Date** _____________________

Flu Vaccine I, the parent/legal guardian/personal representative of _______________________________ (applicant's name), give my consent for the above named individual to receive the flu vaccine. In addition, my signature below indicates that I will not hold EEDA responsible for any liabilities resulting from this procedure.

Parent or Guardian Signature ____ **Date** _________________________

Photo Release I, the parent or Legal Guardian of ______________________________ (applicant's name), give my consent to allow the individual to be photographed / videotaped as part of activities participated in during his/her time at E.E.D.A.

Please check one. ☐ Yes ☐ No

I also agree to allow for the release of photographs/ videotapes for the purpose of making others aware of the nature and functions of EEDA.
Please check one. ☐ Yes ☐ No

Parent or Guardian Signature ___________________________________ **Date** _____________________

Records Release I, the parent or Legal Guardian of ______________________________ (applicant's name), give my consent to _______________________ (name of applicant's school, program or place of employment), to release all pertinent information and all records in their possession concerning the individual to E.E.D.A.
Please check one. ☐ Yes ☐ No

Parent or Guardian Signature ____ **Date** _____________________