East End Disability Assoc. Inc.
107 Roanoke Ave. • Riverhead, NY 11901

Phone: (631) 369-7345
Fax: (631) 369-7346

EEDA
Your Challenge… Our Commitment

# UNIVERSAL FAMILY SUPPORT APPLICATION

*A participating member of the Long Island Family Support Coalition*

Name of Applicant: _____ Date of Application: _____

Social Security #: _____ Medicaid #: _____ Medicare #: _____

Other Med. Insurance: _____ Policy #: _____

Referred by: _____

Completed by: _____

## PARENT/GUARDIAN/CAREGIVER INFORMATION

Parent/Guardian/Caregiver: _____

Home Address: _____

Mailing Address: _____

E-mail: _____

Daytime Phone: _____ Evening Phone: _____

How many people are living at home? _____

| Name(s) | Age |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

## APPLICANT

Date of Birth: _____ Sex: ☐ Male ☐ Female

Height: _____ Weight: _____ Hair Color: _____ Eye Color: _____

Identifying marks or features: _____

_____

Ethnicity/Race (check all that apply)

- ☐ White
- ☐ Black
- ☐ Hispanic
- ☐ Asian/Pacific Islander
- ☐ American Indian/Alaskan
- ☐ Other

Religion: _____

*(Answers to the above questions will not effect eligibility for services.)*

***CONTINUED ON NEXT PAGE***

## EMERGENCY CONTACTS

In case of an emergency, whom should we contact?

Name: _____ Phone #: _____

Name: _____ Phone #: _____

## DISABILITY INFORMATION

*Indicate "1" for primary (mark only one), "2" for all other disabilities.*

- ____ No developmental disability
- ____ Mental retardation
- ____ Autism
- ____ Cerebral palsy
- ____ Epilepsy/Seizure disorder
- ____ Learning disability
- ____ Other neurological impairment
- ____ Psychiatric/Emotional disability
- ____ Chronic physical/Medical condition
- ____ Sensory impairment
- ____ Undetermined
- ____ Traumatic brain injury
- ____ Other _____

Age of onset of disability: _____

## ABILITIES INFORMATION

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

- ____ Interacts with others
- ____ Maintains friendships
- ____ Occupies self independently
- ____ Initiates conversation
- ____ Displays affection appropriately
- ____ Greets appropriately
- ____ Is cooperative
- ____ Accepts limitations
- ____ Controls temper

Please include any other special socialization information that you consider important for the program staff to be aware of: _____

***Behavioral & Safety Concerns:*** Indicate accordingly: 1-Never 2-Sometimes 3-Often 4-Always

- ____ No problems
- ____ Physically assaultive
- ____ Self-Injurious
- ____ Extreme mood changes
- ____ Actively resists supervision
- ____ Verbally abusive
- ____ Sexual misbehavior
- ____ Temper tantrums
- ____ Hyperactive
- ____ Elopement/Wandering

Please include any other special information (ie: habits/behaviors) that you consider important for the program staff to be aware of: _____

Is there anything that makes the participant particularly fearful? _____

_____

***CONTINUED ON NEXT PAGE***

***Communication Skills***

Language (check all that apply)

Spoken: English Spanish Other spoken_____

Limited language: (please describe) _____

Non-verbal: Sign No language Other symbolic

---

***Self Care***

Self Care functional abilities (enter the appropriate # in each category)

1. completely independent
2. needs supervision
3. needs assistance
4. completely dependent

_____ eating _____ dressing _____ toileting _____ bath/shower _____ tooth brushing

If individual is not completely independent, please be specific regarding needs: _____

_____

_____

---

## MEDICAL INFORMATION

***Seizure History***

_____ no history _____ controlled for less than 6 months

_____ controlled more than 6 months _____ uncontrollable

If applicable, does applicant receive medication to control seizures? Yes No

Name of medication: _____ Dosage: _____ Frequency: _____

***Allergies***

Does applicant have any allergies? Yes No

If so, to what? _____

***Other***

Is applicant a Hepatitis B carrier? Yes No

Tuberculosis - PPD skin test? *(New York State Health Department is mandating this test to control and eradicate TB)*

Date: _____ State results in millimeters: _____

Will applicant be administered medication during the program time? Yes No

If so, what medications? _____

Dosage: _____ Frequency: _____ Purpose of medication: _____

***Physical Limitations***

List any physical limitations that the applicant has that you consider important for the program staff to be aware of:

_____

_____

_____

***CONTINUED ON NEXT PAGE***

***Doctor(s)***

**Physician**

Name: _____ Phone #: _____

Address: _____

**Dentist**

Name: _____ Phone #: _____

Address: _____

**Psychiatrist**

Name: _____ Phone #: _____

Address: _____

**Other**

Name: _____ Phone #: _____

Address: _____

## WORK/SCHOOL/DAY PROGRAM

Does applicant attend work/school/day program? Yes No

Name of work/school/day program: _____

Address: _____ Phone #: _____

_____ Contact person: _____

If applicable, please indicate school district: _____

Will you give us permission to speak with the applicant's school or day program staff? Yes No

Will you give us permission to obtain records from the applicant's school or day program? Yes No

Other agencies the applicant is receiving services from: _____

_____

## TYPE OF PROGRAM TO WHICH YOU ARE APPLYING

Family Reimbursement Program

Family Support Group

Day Habilitation

Residential Habilitation

Residential Living Option

Service Coordination (Medicaid Service Coordination)

Environmental Modifications

After School Recreational Therapy Programs (Check one) Westhampton Riverhead

Respite House

Vacation Program

Overnight Emergency Respite

Mobile Crisis Team

***CONTINUED ON NEXT PAGE***

Why do you want the individual to participate in this program? _____

_____

_____

What recreational activities does the individual like to participate in? _____

_____

_____

Is there anything else you would like us to know about the individual? _____

_____

_____

## RELEASES

Parent or Guardian name (please print) _____

***Medications***

I, the parent or Legal Guardian of _____ (individual's name), give my consent to allow the program staff 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 doctors 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 _____ (individual'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:_____**

***Photo Release***

I, the parent or Legal Guardian of _____ (individual'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, I agree No, I do not agree

I also agree to allow for the release of photographs/videotapes for the purpose of making others aware of the nature and functions of E.E.D.A.

Please check one: Yes, I agree No, I do not agree

**Parent or Guardian Signature _____Date:_____**

***CONTINUED ON NEXT PAGE***

***Records Release***

I, the parent or Legal Guardian of _____ (individual's name), give my consent to _____ (name of individual'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, I agree No, I do not agree

**Parent or Guardian Signature _____Date:_____**

# PLEASE ATTACH COPY OF DISABILITY DOCUMENTATION (I.E.P, I.S.P., EVALUATIONS, etc.)