



Day Habilitation Services Application

Applicant's Name: _____ Date: _____

Address: _____

Telephone: _____ Date of Birth: _____

Medicaid #: _____ State: _____ County: _____

Medicare #: _____

Waiver Enrolled: Yes* No * If yes, send a copy of NOD & most current ISP

Diagnosis(es): _____

Medication(s): _____

Does applicant take medications between the hours of 8:00 AM & 3:30 PM?: Yes No

Allergies: _____

Site applicant is interested in:

- | | | |
|---|----------------------------------|---|
| <input type="checkbox"/> East Syracuse | <input type="checkbox"/> Hampton | <input type="checkbox"/> Lakeshore |
| <input type="checkbox"/> Onondaga Blvd. | <input type="checkbox"/> Fremont | <input type="checkbox"/> Galeville |
| <input type="checkbox"/> Midler Ave. | <input type="checkbox"/> Salina | <input type="checkbox"/> OPT's/Retirement Program |

Specific needs or concerns: _____

Emergency Contact Person: _____

Address: _____

Telephone: _____ Relationship: _____

Service Coord: _____ Telephone: _____

Person completing application (if different from above):

Name: _____ Telephone: _____

If applicant has a residential placement, please give information on family and residential caregiver. If residential placement will take place, give information on residential caregiver and expected move date.

Briefly describe applicant's residential arrangement: _____

Family	Residential Caregiver
Name: _____	Name: _____
Address: _____ _____	Address: _____ _____
Phone: _____	Phone: _____
Relationship: _____	Title: _____

Expected Move Date: _____

Does the applicant have a legal guardian?: Yes No

Guardianship type: General (person/property) Limited (property only)

Standby _____ Corporate _____

If yes, please name the legal guardian and give address and phone number, if different from persons named above:

Legal Guardian: _____ Phone: _____

Services Currently Receiving (Res Hab, Day Hab, Workshop, Respite, No Services, etc): _____

Educational/Vocational History:

Names of Schools/Worksites Attended:

Dates Attended:

Does the individual have needs in the following areas? Please check all that apply and provide specific information in the areas below:

Mobility:

- Wheelchair Walker Physical Assistance Independent

Therapy needs:

- PT OT Other (specify): _____

Motor Vehicle:

- Seatbelt use (assistance needed): Yes No
- Supervision during transport: Yes No
- Seating space/needs: Yes No
- Precautions entering/exiting: Yes No
- Air conditioning required: Yes* No

* If yes, a script is needed from a doctor stating what the outside temp. must be

Medical Needs:

- Medication during program Tube feeding Insulin monitoring
- Seizure disorder Use of attends or pull ups
- Life saving devices (epipen, nerve stimulator, etc.): _____
- Other (specify): _____

Dining Needs:

- Must be fed by staff Some physical assistance Independent
- Choking risk Modified textures (specify): _____
- Food allergies (list): _____
- Foods to avoid (other than allergies): _____

Behavioral Concerns:

Property destruction Aggression PICA Elopement

Self injurious behavior Other (specify): _____

Does Behavior interfere with applicant's ability to access the community in a minimum group of 3 consumers to 1 staff?: Yes No

Indicate the frequency of **each** behavior **over the last twelve months** (circle number):

	NOT THIS YEAR	OCCASIONALLY Less than once a month	MONTHLY About once a month	WEEKLY About once a week	FREQUENTLY Several times a week	DAILY Once a day or more
Has tantrums or emotional outburst....	1	2	3	4	5	6
Damages own or others property.....	1	2	3	4	5	6
Physically assaults others.....	1	2	3	4	5	6
Disrupts others' activities.....	1	2	3	4	5	6
Is verbally or gesturally abusive.....	1	2	3	4	5	6
Is self-injurious.....	1	2	3	4	5	6
Teases or harasses others.....	1	2	3	4	5	6
Resists supervision.....	1	2	3	4	5	6
Runs or wanders away.....	1	2	3	4	5	6
Steals.....	1	2	3	4	5	6
Eats inedible objects.....	1	2	3	4	5	6
Displays sexually inappropriate behavior	1	2	3	4	5	6
Smears feces.....	1	2	3	4	5	6

Please provide additional information regarding the above or any other medical or physical restrictions, needs or concerns:

Briefly describe individual's need for day habilitation services and any special interests, issues, or concerns:

Please enclose a copy of the applicant's most current ISP, Waiver Notice of Decision Front and Back, LCED, Psych Eval. and any additional reports that may be helpful.

Signature

Date

Please return to:

Salina Day Habilitation
Attn: Melissa Artini
677 S. Salina Street 1st. Floor
Syracuse, New York 13202

Phone: (315) 579-5625 Fax: (315) 579-0050