



Community Habilitation Services Application

Name: Click or tap here to enter text.

Date: Click or tap to enter a date.

Address: Click or tap here to enter text.

Phone number: Click or tap here to enter text.

Date of birth: Click or tap here to enter text.

Medicaid #: Click or tap here to enter text.

Current Services: Click or tap here to enter text.
Day Hab, Res Hab, Comm Hab, Vocational, etc.

Waiver Enrolled: Yes No

Self-Directed: Yes No In process If yes, please provide a copy of Self-Directed Budget

Family Information

Residential Information

Name: Click or tap here to enter text.

Name: Click or tap here to enter text.

Address: Click or tap here to enter text.

Address: Click or tap here to enter text.

Click or tap here to enter text.

Click or tap here to enter text.

Phone: Click or tap here to enter text.

Phone: Click or tap here to enter text.

Email: Click or tap here to enter text.

Email: Click or tap here to enter text.

Care Manager: Click or tap here to enter text.

Phone: Click or tap here to enter text.

Agency: Click or tap here to enter text.

Email: Click or tap here to enter text.

Day's interested in attending:

Monday Tuesday Wednesday Thursday Friday

Please attach the following:

- Copy of Life Plan
- NOD all pages
- Initial LCED with physician's signature
- Proof of PPD 2-step or an interferon-gamma release assays or IGRAs blood test.
- Copy of Insurance cards (Medicaid, Medicare, and private insurance as applicable).
- Current LCED
- Psychological Evaluation
- Letter of Eligibility

Special needs:

Please check all that apply

Mobility:

- Independent Physical assistance Walker
- Wheelchair

Medical Needs:

- Seizure disorder Lifesaving devise (epi pen, VNS)
- Other: [Click or tap here to enter text.](#)

Dining:

- Independent Some physical assistance Total support
- Choking risk Food allergies: [Click or tap here to enter text.](#)

Behavioral concerns:

	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
Emotional outbursts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Property destruction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physically assaults others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Verbally abusive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-injurious	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Harasses others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Elopement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PICA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Steals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Smears feces	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inappropriate sexual behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Additional information regarding the above or any other medical or physical restrictions, needs or concerns: [Click or tap here to enter text.](#)

Please return completed application to:

Arc of Onondaga
 Attn: Ruth Ann Riposa
 600 S. Wilbur Ave
 Syracuse, New York 13204

ruthann.riposa@arcon.org

Phone: (315) 476-7441 x 1170 Fax: (315) 476-1582