



OPWDD Prevocational Services Application

Applicant's Name: _____ Date: _____

Address: _____

Telephone: _____ Date of Birth: _____

Medicaid #: _____ Current Services: _____
Day Hab, Res Hab, Comm Hab, Other Vocational, etc.

Waiver Enrolled: Yes No

Self-Directed: Yes* No * If yes, provide copy of self-directed budget

Family

Residential Provider

Name: _____

Name: _____

Address: _____

Address: _____

Phone: _____

Phone: _____

Care Manager: _____ Telephone: _____

Email: _____

Number of days applicant is interested in:

Monday Tuesday Wednesday Thursday Friday

Please answer the following questions:

1. Please list your volunteer and/or work history:

What are some places you would like to work?

- Food Service
- Customer service
- Other _____
- Janitorial
- Clerical

Mobility:

- Independent
- Walker
- Physical Assistance
- Wheelchair

Work Accommodations

- Independent
- Cannot lift more than 25lbs
- Assistance needed with writing
- Other
- Cannot stand for more than 15 minutes
- Assistance needed with reading
- Adaptive equipment needed

Dining Needs

- Independent
- Choking risk
- Food needs to be prepared (cut up/ground)
- Food allergies _____

Supervision in the community

- Independent
- General monitoring
- Amount of time can be left alone
- How often visual checks need to occur

Behavior concerns	Occasionally	Monthly	Weekly	Daily
Elopement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emotional Outbursts	<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"/>
Harasses others	<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"/>
Sexually inappropriate	<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:

Please attach:

- A copy of the applicant's most current life plan
- Waiver Notice of Decision (NOD) all pages
- Current LCED
- Initial LCED (with physician signature)
- Current Psychological Evaluation
- Letter of Eligibility Determination
- OPWDD Approval letter to receive CBPV (RSA)
- Copy of Medicaid Card
- Any vocational assessments previously administered
- Self-Directed Budget if applicable

Completed By: _____

Date: _____

Please submit completed application by e-mail, fax or mail to:

Kristen O'Melia
Director of Employment Services
600 Wilbur Ave. Syracuse, NY 13204
Kristen.omelia@arcon.org
Phone: 315-476-7441 ext.1107
Fax: 315-476-1584