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:
   _____

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What are some places you would like to work?

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

Mobility:

- ❑ Independent
- ❑ Physical Assistance
- ❑ Walker
- ❑ Wheelchair

Work Accommodations

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

Dining Needs

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

Supervision in the community

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

Behavior concerns	Occasionally	Monthly	Weekly	Daily
Elopement	❑	❑	❑	❑
Emotional Outbursts	❑	❑	❑	❑
Verbally Abusive	❑	❑	❑	❑
Harasses others	❑	❑	❑	❑
Steals	❑	❑	❑	❑
Sexually inappropriate	❑	❑	❑	❑

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:

Kelsey Gibb, Employment Options Manager
600 South Wilbur Avenue, Syracuse NY 13204
Email: Kelsey.gibb@arcon.org
Phone: (315) 884-0327