Community Habilitation Services
Application

Name: Date:

Address:

Phone number: Date of birth:

Medicaid #: Current Services:

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

Name:
Address:
Phone:
Email:

Care Manager:
Agency:

Residential Information

Name:
Address:
Phone:
Email:

Phone:
Email:

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
☐Current LCED
☐Psychological Evaluation
☐ Letter of Eligibility
☐ 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.

Special needs:

Please check all that apply

Mobility:

☐ Independent ☐ Physical assistance ☐ Walker
☐ Wheelchair

Medical Needs:

☐Seizure disorder ☐Lifesaving devise (epi pen, VNS)
☐Other:

Dining:

☐Independent ☐Some physical assistance ☐Total support
☐Choking risk ☐Food allergies:

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	☐	☐	☐	☐	☐	☐
Property destruction	☐	☐	☐	☐	☐	☐
Physically assaults others	☐	☐	☐	☐	☐	☐
Verbally abusive	☐	☐	☐	☐	☐	☐
Self-injurious	☐	☐	☐	☐	☐	☐
Harasses others	☐	☐	☐	☐	☐	☐
Elopement	☐	☐	☐	☐	☐	☐
PICA	☐	☐	☐	☐	☐	☐
Steals	☐	☐	☐	☐	☐	☐
Smears feces	☐	☐	☐	☐	☐	☐
Inappropriate sexual behavior	☐	☐	☐	☐	☐	☐

Additional information regarding the above or any other medical or physical restrictions, needs or concerns:

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