273 Willoughby avenue. Brooklyn, NY 11205. PH: (718) 832-1075 /fax: (718) 832-1783

SUPPORT PROGRAMS APPLICATION

Interested in applying for: ☐ **Community Habilitation** ☐ **In-Home Respite** ☐ **Site-Based Respite**

DATE: _____

NAME: _____ Gender: Male__ Female__

DOB: _____ Age: _____

Medicaid: No__ Yes__ if yes, Medicaid#:_____ Social Security#:_____

Home Address: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____

Email address: _____

Type of Residence: Family ____ Agency ____
If agency, name and contact information of sponsoring agency
_____

Name of Primary Caregiver: _____ Relationship: _____

Address (If different from above):_____

EMERGENCY CONTACT INFORMATION

Name	Address	Contact Number	Email	Relationship

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Is the applicant receiving Medicaid Service Coordination (MSC) or Case Management? : No__ Yes__ If yes, please provide the following information:

Agency: _____ Name of MSC or Caseworker: _____

Address: _____ Phone #:_____

Fax#_____

Primary Diagnosis: _____ Secondary Diagnosis: _____

COMMUNICATION SKILLS

Is the individual (Circle one):	**verbal**	**non-verbal**	**hearing impaired**
Does the individual use sign?	**Yes**	**No**	
Use picture boards?	**Yes**	**No**	
Communication devices?	**Yes**	**No**	

If yes, what kind: _____

MEDICAL/EMERGENCY INFORMATION:

Does the individual currently or have a history of any pertinent medical conditions (IE – seizure disorder, hypertension, diabetes, etc.)? If so, please provide detailed information:

_____

_____

_____

Does the individual have any special health care needs that we should be aware of (IE – known allergies to foods/drugs, special diet orders, etc.)?: No _____Yes _____If yes, please provide detailed information: _____

_____

Is the individual able to report pain? Yes_____No_____If no, how would we know that the individual does not feel well? _____

Does the individual take any medication? No_____ Yes_____ If yes, please provide us with the following information:

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Medication	Dose	Reason	Possible Side Effects

Primary Care Physician: _____Phone #:_____

Address: _____

Other: _____Phone #:_____

Address: _____

BEHAVIORAL INFORMATION:

Does the individual exhibit or have a history of exhibiting any of the following behaviors? (Please check all that apply)

Excessive eating	food stealing	chokes easily	urinates	property destruction
Vomiting	refuses to eat	refuses to drink	eats very fast	window breaking
Eats very slowly	throws food	hitting	self-injury	throws objects
Biting	cries easily	running away	spitting	repeats words or phrases
Head banging	kicking			

Does the individual have outbursts? (Circle one) Yes No

If yes, how frequent are these outbursts?

Daily Weekly Monthly

What kind of outbursts does the individual have?

For all areas circled, please describe: _____

_____

_____

_____

_____

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What should we do when the individual is upset, frustrated, etc., in an effort to help them regain control and/or feel better (i.e. talk with them, give personal space, listen to music, etc.)?_____
_____
_____
_____

What types of things reinforce/motivate the individual? (I.e. verbal praise, computer time, snack, etc)?_____
_____

Does the individual currently possess any independent travel skills? No: ____Yes____
If yes, please describe (walks from home to local store, is able to cross streets, can take bus or subway to movie theater, etc.): _____
_____
_____

What level of supervision does the individual require in the community? _____
Why? _____
_____

Are there any environmental issues that would be important for us to know (i.e. sensitive to loud noises, doesn't like crowds, fears or phobias, etc.) No _____Yes _____ if yes, please explain:
_____
_____

Is there anything else you think would be important for us to know about the individual? ____
_____
_____

<u>SCHOOL/PRIOR PROGRAM EXPERIENCE:</u>
Is the individual currently in school or day program? No_____ Yes_____

If yes, Name of School_____
School Address_____
School/Program Phone #:_____**Contact Person:** _____
Anticipated Date of Graduation: _____

Please list current and past day program affiliations:

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Agency:	Address:	Phone #:	Contact Person:	Type of Program (day hab, SEMP, etc.):	Reason for leaving:

Completed By:

_____

Name **Relationship** **Signature** **Date**

Intake Conducted By:

_____

Name **Title** **Signature** **Date**

For internal use:
Summary/Comments (including next steps, follow up, referrals, etc.)_____
_____
_____