

**Universal Application for Services
(Confidential Information)**

Please check applicable service/services: Residential Day Hab/Work Respite Community Habilitation

Completed by:		Relationship:			
Service Coordinator:		Date completed:			
Agency:		Phone #:		Ext.:	
Address:		Fax #:		E-Mail:	
Application Data					
Name:		Phone #:	Tabs #:	Primary Language:	
Address:		Current Living Situation:			
City:	County:	Zip Code:	Gender:		Birth Date:
Citizenship:		Religion:	Social Security #:		
Developmental Disabilities					
Intellectual Disability: (Circle One) Mild Moderate Severe Profound					
Epilepsy:		Cerebral Palsy:	Autism:	Neurological Impairment:	
Psychiatric diagnosis:			Other:		
Verbal:		Non-verbal (please specify):			
Ambulatory: Yes or No		Explain any Mobility Supports needed:			Stairs: Yes or No
Level of Supervision required - Home: Community:					
Family/Caregiver/Emergency Contact Information (Circle One)					
Name:		Relationship:		Primary Language:	
Address:		City:		Zip:	
Home #:		Work#:			
Guardian/Advocate information (Circle One)					
Name:		Phone #:		E-Mail:	
Address:		City:		Zip:	
Do they have a Legal Guardian? Yes or No		Who:			
Emergency Information					
Hospital:					
Health Insurance Co.:					
Policy #:		Name on Policy:			
Medicare #:		Medicaid #:			
DNR Order: Yes or No		Health Care Proxy: Yes or No		Living Will: Yes or No	

**Universal Application for Services
(Confidential Information)**

Medical Information (attach any additional information)

Name of Primary Physician:			
Address:		Date Last Seen:	
Name of Dentist:			
Address:		Date Last Seen:	
Other Physician:		Specialty:	
Other Physician:		Specialty:	
Other Physician:		Specialty:	
Other Physician:		Specialty:	

Present Medications

Pharmacy:					Phone #:	
Drug	Dosage	Times Given	Reason	How Administered/By Whom	Route Given	

Height:	Weight:	Seizures: Yes or No	Description:
Visual Impairments: Yes or No	Wears Glasses: Yes or No	Legally Blind: Yes or No	
Hearing Impairments: Yes or No	Wears Hearing Aid: Yes or No	Allergies: Yes or No	
Allergy	Typical Reaction	Treatment	

Special Medical Needs

Suctioning: Yes or No	Injections: Yes or No	Respiratory Therapy: Yes or No	Oxygen: Yes or No
Dressing/Wound Care: Yes or No	Other:		
Health Concerns:			
Surgical History:			

**Universal Application for Services
(Confidential Information)**

Income Sources (Residential Only)				
SSI \$	SSD \$	Public Assistance \$	Food Stamps \$	Other income \$
Waiver enrolled: Yes or No		Other Funding Source:		
Assets (Life insurance, trust funds, Burial funds, Property, CD's)				

Transportation Abilities (Circle all that apply)
Public transportation / Family provides transportation / Medicaid cab / Drives own car / Other:

Current Agency Affiliations	
Service Provided:	Agency Providing:
Address:	
Phone #:	Contact Name:
Service Provided:	Agency Providing:
Address:	
Phone #:	Contact Name:
School:	Graduation Date:
Address:	
Phone #:	Contact Name:

Fire Evacuation Ability		
Will respond to fire alarm	Will leave house independently	Needs help to leave
Verbal prompts	Physical assistance	Total Assistance

Meal Time											
Eating	Independent	Needs Help	Dependent	Eating	Independent	Needs Help	Dependent	Eating	Independent	Needs Help	Dependent
Feeds Self				Drinks				Pours Drink			
Cuts Food				Cleans Self				Bottle Fed			
Utilizes G- Tube feeding: Yes or No	Uses Adaptive Feeding Equipment: Yes or No		Fork: Yes or No	Spoon: Yes or No	Plate: Yes or No	Cup: Yes or No	Other:				
Are there any difficulties eating due to: (Circle all that apply)											
Drooling / Bite Reflex / Gagging / Chewing / Sucking / Choking / Swallowing / Unable to close mouth / Biting pieces of food / Eats slowly											
Describe how to best assist the person during eating:											
Special Diet:						Food Allergies:					
Favorite Foods:						Disliked Foods:					

**Universal Application for Services
(Confidential Information)**

Self – Care											
	Independent	Needs Help	Dependent		Independent	Needs Help	Dependent		Independent	Needs Help	Dependent
Washes Body				Brushes Teeth				Tub/Shower			
Shampoos Hair				Combs Hair				Menstruation Care			

Dressing / Toileting											
Wears briefs/Diapers: Yes or No				Toilet Schedule: Yes or No				Adaptive Equipment: Yes or No			
	Independent	Needs help	Dependent		Independent	Needs help	Dependent		Independent	Needs help	Dependent
Dresses self				Zips				Socks			
Pants				Buttons				Tie Shoes			
Shirt				Undergarments				Select Clothes			
Undresses self				Manages clothing				Washes hands			
Transfers from chair to toilet				Initiates				Manages toilet tissue			
Self toilets											

Are there any special problems with bowel movements and/or urinary problems? (Explain)

Behavior											
-----------------	--	--	--	--	--	--	--	--	--	--	--

Indicate frequency of behavior by using code: **D** = Daily, **W** = Weekly, **M** = Monthly, **N/A** = Not Applicable

No Problems:	Eats In-edibles:	Wanders/runs away:	Destroys property:
Non-compliance:	Bites:	Inappropriate sexual behavior:	Other:
Hits / Kicks:	Verbal Abuse:	Self injurious behavior:	
Smokes:	Pulls Hair:	Spits:	

Precipitating factors/causes:

How are these behaviors supported:

Reinforcers:

Sexuality - Consenting; Yes or No | Comments:

Interests or Hobbies (please explain):

Dislikes (please explain):

Fears (please explain):

Additional information not previously covered:

Any Legal Issues (Please Explain):

**Universal Application for Services
(Confidential Information)**

Sleep Patterns					
Wears to bed:		Bedtime:		Wake-up time:	
Sleeps through the night: Yes or No		Uses bed rails: Yes or No		Door: Open / Closed	
Toileted/Changed during night: Yes or No		If yes, what times:		Naps: Yes or No	
Bedtime routine / Problems:					
Positioning:			Other:		

Residential Need					
Group setting		Intermediate Care Facility (ICF)		Family Care:	
Apartment style: Supportive / Supervised		Share Bedroom: Yes or No		NY State Cares enrolled: Yes or No	
Independent with supports		Other Information (i.e.: pets):			
Comments:					
Geographical Preference: 1)		2)		3)	
How soon is placement desired: _____ (Immediately) _____ (Under 2 years) _____ (3-5 years) _____ (5 or more years)					

Day/Other Services Requesting							
Program or Service Requested:							
Days	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Hours Requested							
Desired Goals:	1)		2)		3)		
Program or Service Requested:							
Days	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Hours Requested							
Desired Goals:	1)		2)		3)		
Program or Service Requested:							
Days	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Hours Requested							
Desired Goals:	1)		2)		3)		

