300 Washington Avenue Extension
Albany, New York 12203
Phone: 518-218-0000
Fax: 518-862-2175

Thank you for applying to Living Resources for services. We want to make this process as complete and accurate as possible. Living Resources currently provides over 600 services daily throughout the Capital Region. These services include:

- Supported and independent living
- Employment support program
- After school program
- Service coordination
- At-home services
- Day Hab Services
- Specialized professional services such as:
    - ❖ Interpreter services for the hearing impaired
    - ❖ Licensed professional counseling services
    - ❖ Art instruction

Enclosed are several pages of necessary documentation to be completed by the applicant, family and/or advocate. If you need assistance or have any questions in completing the application, please feel free to call us for assistance.

This application is a request for information required under the Mental Hygiene Law. After the application is completed in full, we will be able to assess the applicant's eligibility for various federal and state programs including Medicaid. It is our policy that if public funding sources do not fully cover the cost of care, then insurance or private funds from the applicant or family will be necessary to pay the remainder. This arrangement will be discussed and finalized prior to the start of service.

Once again thank you for considering Living Resources Corporation. We hope that we can assist you in getting the services you need. Please return your completed application along with all the appropriate paper work to me at the above address.

Sincerely,

Jennifer Richard
Director of Intake
(518) 218-0000 ext. 5537

Application for Services
For Families and Agencies in the Capital District

This application (or a copy) can be used to apply to all agencies in The Capital District DDSO

Attachments to be submitted with the application

1. **Copy of a recent physical examination**
2. **Copy of recent psychological evaluation that clearly states disability**
   - **If the individual has developmental disabilities, must document onset of disability prior to the age of 22**
   - **Include adaptive behavior scale (usually done as part of the psychological evaluation)**
3. **Copy of Individualized Service Plan (ISP) or Comprehensive Social History**
4. **Copy of Program (IEP, Day Services Plan, etc.) as Applicable**
5. **Copy of DDP-4 if available**
6. **Copy of NYS Cares Priority Form if available (For residential referrals)**

Please retain a copy of the completed application for your own records

For Agency Use:			
Is the individual on the NYS Cares Waitlist?	**YES**	**NO**	**DON'T KNOW**
Priority Number:			
Has a DDP 4 been submitted?	**YES**	**NO**	**DON'T KNOW**
If Yes, by which agency?			

AGENCY NAME (optional)

Universal Application

For Families and Agencies in the Capital District

Date Received:_____

SERVICES YOU ARE INTERESTED IN RECEIVING: (Check all that apply)

[ ] Day Services [ ] Residential Services [ ] In-Home Services [ ] Respite [ ] Recreation

[ ] Service Coordination [ ] Supported Employment [ ] Family Support Services [ ] Clinic Services

[ ] Other (describe)_____

_____

What is your timeframe?_____

APPLICANT DATA:

Name:_____ Birth date:_____ Gender: Male Female (circle one)

Address:_____ Marital Status:_____

_____ U.S. Citizen? Yes No (Circle One)

_____ Soc. Sec. #:_____

County of Residence:_____ Telephone # ( )_____

Does applicant have dependent children? Yes No How many? _____

CONTACT: (Parent, Guardian, Caregiver)

Name:_____ Relationship:_____

Address:_____

_____

Day Telephone # ( )_____ Eve Telephone # ( )_____

REFERRAL SOURCE:

Name of Agency or School:_____

Contact Person: (if different from above)_____

Address:_____

Phone # ( )_____

LEGAL GUARDIAN (COURT APPOINTED IF OVER 18):

Name:_____ Phone # ( )_____

Address:_____

AGENCY NAME (optional)

MEDICAL INFORMATION:

Developmental Disability/Diagnosis:_____

Medical Diagnosis:_____

Psychiatric Diagnosis:_____

History of Hospitalization_____
(medical and/or psychiatric)
_____

MEDICATION(s):

Name:_____ Reason for Medication:_____

Name:_____ Reason for Medication:_____

Name:_____ Reason for Medication:_____

Ongoing Medical Treatments needed: (G-Tube feeding, Chemotherapy, Kidney Dialysis, etc.)

_____

_____

Allergies: (food, medication. Other):_____

Date of last Tetanus:_____ TB Status (last Screening):_____
(Please be aware that a current PPD or Mantoux, and a HEP B screen will be required for most programs prior to admission)

Circle the response that best describes applicant's functioning in the following areas (indicate the one that best applies)

1. Hearing deficit Yes No
2. Visual deficit Yes No
3. Walking ability
   a. Independent
   b. With difficulty
   c. Corrective device
   d. Assistance from Caregiver
   e. Cannot walk
4. Can independently climb stairs? Yes No
5. Does applicant use a wheelchair? Yes No

AGENCY NAME (optional)
Mark the one response that best describes wheelchair (may e motorized) mobility:

1. Can use wheelchair independently, including transfer.
2. Can use wheelchair independently with assistance in transferring.
3. Requires assistance in transferring and moving.
4. No Mobility – Must be transferred and moved.

Comments:_____

_____

Describe any adaptive equipment used:_____

_____

_____

PRIMARY PHYSICIAN:

Name:_____ Phone: ( )_____

Address:_____

OTHER SPECIALISTS:

Name:_____ Phone: ( )_____

Address:_____

Name:_____ Phone: ( )_____

Address:_____

EDUCATIONAL/VOCATIONAL INFORMATION: (Begin with the most recent. List name of school/program or employment, type of class, dates of attendance, etc.)

1. _____

_____

2. _____

_____

3. _____

_____

Does the applicant have an open VESID case? Yes No

Name of Counselor:_____

AGENCY NAME (optional)

COMMUNICATION SKILLS:

Verbal:_____ Describe level of ability:_____

Primary Language (Spoken)_____

(Understood)_____

Non-Verbal:_____ Uses Sign Language_____

Describe how much sign is used or other methods of communication:

_____

_____

Additional Comments:

_____

_____

DAILY LIVING SKILLS:

What assistance does the applicant need in the area of Toileting?_____

_____

What assistance does the applicant need for Eating/ Drinking?_____

_____

What assistance does the applicant need to be safe in the home?_____

_____

What assistance does the applicant need to be safe in the community?_____

_____

RECREATION / LEISURE TIME ACTIVITIE:

1. What does the applicant enjoy doing in their spare time?_____

_____

2. What activities does the applicant have an interest in doing or achieving? (Learning to cook, exercising, learning to read, etc.):

_____

_____

AGENCY NAME (optional)

BEHAVIORS: For each, describe what causes the behavior, how often it happens, and how severe it is.

1. Aggressive Behaviors (verbal/physical) _____

_____

_____

2. Damages own or others property

_____

_____

3. Injury to self (include eating inedible objects)

_____

_____

4. Refuses to follow direction or accept supervision or help:

_____

_____

5. Sexually inappropriate behaviors:

_____

_____

6. Runs or Wanders Away

_____

_____

7. Takes belongings of others

_____

_____

8. Other

_____

_____

What methods do you use to deal with challenging behaviors the individual presents?

_____

_____

AGENCY NAME (optional)

SUBSTANCE ABUSE

Are there or have there ever been any concerns with substance abuse, including alcohol? Yes No

If yes, Please explain_____

_____

CRIMINAL JUSTICE

Has the applicant ever been involved with the criminal justice system? Yes No

If yes, Please explain_____

_____

FINANCIAL BENEFIT INFORMATION:

Applicant receives Supplemental Security Income (SSI) Yes No

Applicant receives Social Security or Disability Benefits (SSA, SSDI) Yes No

Applicant currently receives Medicaid Yes No

Medicaid #_____ County:_____

Applicant currently receives Medicare Yes No

Medicare #:_____

Applicant is covered under Other Health Insurance Yes No

Insurance Company_____

Policy Holder_____ Date of Birth_____

Policy Number:_____ Group Number_____

Applicant receives Benefits/Income not listed (Veteran's, Railroad, Trust Fund)

_____

_____

Is there any additional information you wish to share that is not included in this application?

_____

_____

_____

_____

AGENCY NAME (optional)

Are you currently receiving services from any other agency? Yes No
(Service Coordination, Reshab, Respite, etc.)

Is the applicant HCBS enrolled? Yes No Don't Know

Agency Name:_____

Type(s) of Service:_____

Name of Contact:_____ Phone: ( )_____

I hereby verify that all of the above information is correct and accurate to the best of my knowledge.

Applicant:_____ Date:_____

Parent/ Guardian_____ Date:_____
(if applicable)

Person completing application:_____

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Please retain a copy of the completed application for your own records

AGENCY NAME (optional)