Application for In-home Behavioral Support for Individuals with Autism and/or Dual Diagnosis and Their Families

A New Program funded through a Family Support Grant from OPWDD

CONTACT INFORMATION

Alison Belden, Manager, Community Behavior Services

Phone: (518) 925-0726

Fax: (518) 880-1812

Email: *arnold@cfdsny.org*

Mailing Address:

Alison Belden

Center for Disability Services

22 Corporate Woods Blvd.

Albany NY, 12208

HOW TO APPLY

1. Complete the requested information in each section carefully and completely.
2. In order to best meet the needs of the individual, we will need you to attach:
   - Previous or Current Behavioral Intervention Plans
   - Most recent Individualized Education Plan
   - Most recent Individualized Support Plan (if one exists)
   - Most recent Psychological/Psychiatric Evaluation
   - Documentation of Diagnosis
   - OPWDD (formally OMRDD) Determination of Eligibility Letter
3. Return the ***complete*** application to: Center for Disability Services, 22 Corporate Woods Blvd., Albany, NY 12211, Attn: Alison Belden

ADDITIONAL INFORMATION

1. This participation in this program is contingent on meeting admission criteria and availability
2. Participants are not enrolled until they receive a confirmation and/or phone contact.

SECTION 1: PERSONAL INFORMATION

Individual's Name: _____ Gender: ☐ Male ☐ Female

Address: _____ Phone Number: _____

_____ County: _____

Age: _____ Date of Birth: _____

Disability (Please specify): _____

Is the individual on a residential wait list? Yes ☐ No ☐

Does the individual have self-direction? Yes ☐ No ☐

Guardianship status (if applicable): _____

Current Programs and Services: **Make a list under Section 3 "Other Providers."**

Person Completing Application: _____ Relationship to individual: _____

Address: _____ Parents/Guardian Home Phone Number: _____

_____ Work Phone Number: _____

Email: _____ Fax Number: _____

SECTION 2: PARENT/GUARDIAN INFORMATION

Name: _____ Relationship to Applicant _____

Address: _____ Phone Number: _____

_____ Alternate Phone Number: _____

Name: _____ Relationship to Applicant: _____

Address: _____ Phone Number: _____

_____ Alternate Phone Number: _____

Name: _____ Relationship to Applicant: _____

Address: _____ Phone Number: _____

_____ Alternate Phone Number: _____

SECTION 3: PHYSICIAN INFORMATION

Individual's Primary Care Physician: _____ Address: _____

Phone Number: _____ _____

Psychiatrist:

Psychologist:

Other Providers (counseling, service coordination, Medicaid waiver, etc.):

SECTION 4: GENERAL MEDICAL INFORMATION

Does the individual have a seizure disorder? ☐ YES ☐ NO

Describe how often, type, duration, characteristics, etc. _____

Is the individual: ☐ Ambulatory ☐ Non-ambulatory

Does the individual ever use a walker or wheelchair? ☐ YES ☐ NO Please specify. _____

How does the individual communicate? (verbal, sign, special device, communication book)_____

_____

Has there been any involvement with police, child protective service (CPS)? ☐ YES ☐ NO Please specify. _____

_____

_____

SECTION 5: BEHAVIORAL PROBLEMS

Aggressive behavior towards another person ☐ YES ☐ NO Details: _____

Self-injurious behaviors ☐ YES ☐ NO Details: _____

Suicidal threats (words) ☐ YES ☐ NO Details: _____

Suicidal gesture (Attempt to harm) ☐ YES ☐ NO Details: _____

Suicidal attempt ☐ YES ☐ NO Details: _____

Other unsafe behaviors ☐ YES ☐ NO Details: _____

Calls to crisis services ☐ YES ☐ NO Details: _____

Psychiatric Hospital Admissions ☐ YES ☐ NO Details: _____

If yes, please include any discharge paperwork

Eating Concerns ☐ YES ☐ NO Details:_____

Other Behavioral Concerns_____

_____

Which of these concerns you the most? _____

What is your goal for participating in this program? _____

_____

SECTION 6: INTERESTS

Please list interests and hobbies:

What is motivating and/or rewarding?

SECTION 7: ADDITIONAL INFORMATION

Does the individual have any strong fears (e.g. darkness, water, thunder, bugs)? _____

_____

_____

_____

How does the individual react when upset or frustrated?_____

_____

_____

_____

What methods have been used to address any behavior problems?_____

_____

_____

What has been most effective in addressing these behaviors? _____

_____

Is there any further information that may be helpful in better understanding the individual and his/her needs? _____

Current Medications

1.	Medication Name	Name of Physician Who Ordered Medication
	Frequency of Administration	Dosage
2.	Medication Name	Name of Physician Who Ordered Medication
	Frequency of Administration	Dosage
3.	Medication Name	Name of Physician Who Ordered Medication
	Frequency of Administration	Dosage
4.	Medication Name	Name of Physician Who Ordered Medication
	Frequency of Administration	Dosage
5.	Medication Name	Name of Physician Who Ordered Medication
	Frequency of Administration	Dosage

By signing here as the above applicant's Parent/Guardian/Advocate, I certify that all of the above information is correct to the best of my knowledge. I also agree to fully participate in this program and follow through on behavioral suggestions provided.

Parent/Guardian/Advocate Signature **Date**