L'ARCHE® LONG ISLAND
PO Box 354 Riverhead, NY 11901 631.381.0244

CORE MEMBER INFORMATION FORM

Core Member's Information

Name: _____ Date: _____

Previous Address:
_____

Previous Phone: _____Previous Cell Phone: _____

Date of Birth: _____

Birthplace: _____

Email: _____

OPWDD Eligibility Yes/No If yes as of what date: _____

Does Core Member have a Medicaid Service Coordinator: □ Yes □ No

Agency Name:
_____

Name of Medicaid Service Coordinator: _____

Phone: _____

Is the applicant enrolled in the HCBS Waiver: □ YES □ NO Enrollment date: _____

DISABILITIES
(*Please check all that apply*)

Age of Onset of Primary Disability

___Intellectual Disabilities (ID)
___Epilepsy/Seizure Disorder
___Autism
___Asperger's Syndrome
___Cerebral Palsy

___Familial Dysautonomia
___Down's Syndrome
___Learning Disability
___Sensory Impairment
___Physical/Medical Condition
___Psychiatric Disability
___Traumatic Brain Injury *(Prior to age 22)*
___Tourette syndrome
___Spina Bifida
___Prader Willi
___Other Neurological Impairment

Describe:_____

COGNITIVE ABILITY

Verbal I.Q._____Performance I.Q._____ Full Scale I.Q._____

Vineland II Adaptive Score_____ ID Level: _____

BENEFIT INFORMATION

US Citizen or National: Yes or No Lawful Permanent Resident #: A_____

Social Security #: _____

Is the applicant covered by Medicaid: □Yes □ No

If YES: Medicaid Identification Number (CIN)_____ Date Approved: _____

HMO Plan (if applicable): _____

If NO: Was a Medicaid application filed? □Yes □ No If YES, complete the following:

Date of application: _____Date of denial: _____

Reason for denial: _____

Medicare #: _____ Parts A/B/D Part D Drug Plan: _____

Primary Insurance: Policy Holder: _____

Policy #:_____ Group # _____

SSI Benefits: Yes / No SSD Benefits: Yes /No Supplemental Needs Trust (SNT): Yes/No

Representative Payee for Benefits:

Name: _____

Address: _____Phone: _____

Is the applicant Employed: Yes/No: If Yes: Where: _____

How long:_____

PARENT / GUARDIAN / CAREGIVER INFORMATION

Mother	**Father**
Name: _____	_____
Address: _____	_____
Home Phone: _____	_____
Work Phone: _____	_____
Cell Phone: _____	_____
E-Mail: _____	_____
Court Appointed Guardian? Yes /No	If Yes relationship: _____

If Yes: Date of Appointment and Location of Court_____

If there is a court appointed guardian(s), please so provide a copy of the guardianship papers.

Siblings

Name:	Age:	Reside at Home:
Name:	Age:	Reside at Home:

Other Household Members / Other Primary Care Giver

Name: _____ Relationship to applicant: _____

APPLICANT'S CURRENT DAY ACTIVITY

(check all that apply)

□ School (graduation year____	□Day Program	□ Place of Employment
School Name _____	Program Name: _____	Employer _____
Tel # _____	Tel # _____	Tel # _____
	Days Scheduled:_____	Days Scheduled:_____

Home #: _____Work #: _____ Cell #: _____

Who of the above is the primary contact person and when is the best time to call?

_____

Emergency Contact Details:

Name: _____ Relationship: _____Phone #:_____

Name: _____ Relationship: _____Phone #: _____

PERSONAL INFORMATION

Gender: Male □ Female □ Height: _____ Weight: ____ Hair Color: _____ Eye Color: _____

Identifying Marks and/or Features:

_____

Ethnicity/Race: - Answers will not affect eligibility for services

□ White

□ Asian or Pacific Islander

□ African American

□ American Indian/Alaskan

□ Hispanic

□ Other

Religion:

Primary Language Spoken

□ English □ Spanish □ French □ Other_____

Which best describes the applicant's hearing? □ Normal □ Mild/Moderate □ Severe/Profound loss

□ Sensitivity to Noise

Does the applicant use a hearing aid? □ Yes □ No

Which best describes the applicant's vision? □ Fully sighted □ Moderate impairment

□ Severe impairment □ Blind

Does the applicant use glasses? □ Yes □ No

COMMUNICATION

Check the responses that best describes the applicants method of communication

□ Verbal

□ Uses signs or communication device

□ Uses gestures, vocalizations

□ Unable to communicate

AMBULATION

___Walks Independently ____Unsteady Gait _____Walks with Physical Assistance

_____Requires Use of Wheelchair _____ Uses Other Adaptive Equipment to Ambulate *(If yes, please describe)* _____ _____

ABILITIES AND STRENGTHS

Socialization: Indicate accordingly: 1. Never 2. Sometimes 3. Often 4. Always

___ Interacts with others

___ Displays affection appropriately

___ Maintains friendships

___ Greets appropriately

___ Occupies self independently

___ Is Cooperative PERSONAL INFORMATION

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□ Normal □ Mild/Moderate □ Severe/Profound loss

□ Sensitivity to Noise

Does the applicant use a hearing aid?

□ Yes □ No

Which best describes the applicant's vision?

□ Fully sighted □ Moderate impairment

□ Severe impairment □ Blind

Does the applicant use glasses?

□ Yes □ No

SELF CARE

Indicate accordingly: 1.Independent 2. Needs supervision 3. Needs assistance 4. Completely dependent

___ Eating
___ Dressing
___ Toileting
___ Bathing / shower
___ Tooth brushing
___ Shaving
___ Menses
___ Administering medications

Please include any other special self-care information that you consider important for the program staff to be aware of?

BEHAVIOR PROFILE

(Please indicate frequency)

0=Never 1=Daily 2=Weekly 3=Monthly 4=Every 3 Months 5=Every 6 Months

__No Problems
__Self-Injurious
__Sleeping Disorders
__Verbally Abusive
__Temper Tantrums
__Destroys Property
__Enuresis
__Impulsive
__Physically Assaultive
__Withdrawn
__Eating Disorder
__Sexual Misconduct
__Alcohol/Substance Abuse
__False Statements
__Mood Changes
__Non-Compliance
__Pica
__Fire Setting
__Stealing
__Smears Feces
__Elopement
__Teasing
__Hyperactive
__Wanders

COMMENTS: Please indicate other pertinent information related to unusual or maladaptive behaviors and/or psychiatric symptoms (i.e., how often do behaviors/symptoms occur?)

_____

_____

_____

_____

MEDICAL HISTORY

Medical needs: Please list any medical conditions or needs that may impact the individuals, such as seizures or diabetes, etc.

_____

_____

_____

Allergies:

Medication Allergies: _____ Reaction: _____
Food Allergies: _____ Reaction: _____
Environmental Allergies: _____ Reaction: _____

Other: Tuberculosis- Mantoux /TB/PPD skin test:

●Reason for a Mantoux test:

o New York State Health Department mandates this test to control and eradicate TB

●f the test results are Negative:

o *As per the June 2010 regulation two negative PPD's are required. The first negative followed in 1-3 weeks by the second. If both negative this is documented & an annual screening by a health care provider is appropriate.*

●f the test results are positive:

o If there is a positive PPD result, a chest x-ray (within two years) and a note from the doctor, within a year, stating the individual is clear of communicable diseases is required.

●f the family refused the PPD testing:

o A note from the doctor, within a year, that the individual is clear of communicable diseases is required.

DOCUMENTATION MUST BE ATTACHED

NUTRITION

Please indicate if there are any special dietary requirements or any food restrictions:

_____

_____

_____

MEDICAL / DENTAL PROVIDERS

Physician's Name: _____

Address: _____

Phone: _____

Dentist's Name: _____

Address: _____

Phone: _____

Psychiatrist's Name: _____

Address: _____

Phone: _____ _____

Specialist's Name: _____

Specialty: _____

Address: _____

Phone: _____

Specialist's Name: _____

Specialty: _____

Address: _____

Phone: _____

Other Providers: _____

Address: _____

Phone: _____

CURRENT MEDICATIONS

Medication_____

Dose (amount/frequency/time)_____

Prescribed By_____

Diagnosis_____

Medication_____

Dose (amount/frequency/time)_____

Prescribed By_____

Diagnosis_____

Medication_____

Dose (amount/frequency/time)_____

Prescribed By_____

Diagnosis_____

Please attach additional sheets if needed

DOCUMENTATION

Please be sure to attach copies of the documents indicated below. All information must be within the last 1 (one) year unless otherwise noted.

The following documents are required as part of the Universal Application

Required Document	**Attached**	**Date**
Annual Physical Exam		
Immunization (PPD info on page 6)		

Psychological Evaluation (Must be within 3 years)

Adaptive Behavior Scale, ie., Vineland, ABAS, etc. (Must be within 3 years)

Psycho-Social Evaluation (Must be within 3 years)

Level of Care Eligibility Determination (LCED) (if waiver enrolled)

Notice of Decision (NOD) (if waiver enrolled)

Copy of Medicaid Card (if applicable)

OPWDD Eligibility Determination

Privacy Practices Sign Off

Signed consent for release of information

Signatures:

By signing below you agree that this application MAY be used to apply to all agencies in the Long Island DDSO; You also understand that additional paperwork may be needed for individual agencies and programs.

By signing below I confirm that the information provided in this application is complete and accurate to the best of my knowledge.

I understand that failure to provide comprehensive and accurate information may result in the applicant's non-acceptance into an agency's program.

Core Member: _____ _____
Date:_____

Parent/Advocate/Guardian: _____
Date_____

Person completing application_____Date_____

Referred by: _____Phone_____

RELEASES

Medications I, the parent or legal guardian of _____ (Core Member's name), give my consent to allow the program coordinator to give medication as stated on a written doctors' order/prescription. An updated physicians prescription must be provided and maintained at the participants program. I further agree to supply enough medication in the original container for each day that the individual attends program. I understand that failure to submit a doctor's order will result in the individual not receiving medication during his/her time with us.
Parent or Guardian Signature _____
Date_____

Emergency Medical Treatment I, the parent or legal guardian of _____ (Core Member's name), give my consent to allow L'Arche Long Island to provide emergency medical treatment if needed. I understand that all efforts will be made to reach me in the event of a medical emergency. In addition, my signature below indicates that I will not hold L'Arche Long Island responsible for any liabilities resulting from participation in this program.
Parent or Guardian Signature _____
Date _____

Flu Vaccine I, the parent/legal guardian/personal representative of _____ (Core Member's name), give my consent for the above named individual to receive the flu vaccine. In addition, my signature below indicates that I will not hold L'Arche Long Island responsible for any liabilities resulting from this procedure.
Date _____

Photo Release I, the parent or Legal Guardian of _____ (Core Member's name), give my consent to allow the individual to be photographed / videotaped as part of activities participated in during his/her time at L'Arche Long Island.
Please check one. □ Yes □ No
I also agree to allow for the release of photographs/ videotapes for the purpose of making others aware of the nature and functions of L'Arche Long Island. Please check one. □ Yes □ No
Parent or Guardian Signature _____
Date _____

Records Release I, the parent or Legal Guardian of _____ (Core Member's name), give my consent to _____ (name of Core Member's school, program or place of employment), to release all pertinent information and all records in their possession concerning the individual to L'Arche Long Island. Please check one. □ Yes □ No
Parent or Guardian Signature _____

Date _____