



Dear Applicant,

We are pleased that you are considering Life's WORC programs for either yourself, a loved one or a person you advocate for. You will find an application for services attached. In order to expedite the intake process it is imperative that the application is completed in its entirety. We also ask that required documents are attached as part of the application packet. **Please be aware that your application for services cannot be processed without the requested information provided.** If you are enrolled in the Medicaid Waiver, your Medicaid Service Coordinator can assist you with securing needed documentation.

We can only begin the intake process upon receipt of a fully completed application packet.

Name of Applicant: _____ Date: _____

Document	√ Document attached	FOR LIFE'S WORC USE ONLY	
		Document Accepted	Document Required
Annual Physical Exam with PPD (See attached guidelines)			
Annual ISP (if applicant receives MSC services) Note: ISP Addendum must be submitted once applicant is accepted into a program			ISP Addendum Requested on: _____
Psycho-Social Evaluation (Must be within 3 years)			
Psychological Evaluation (Must be within 3 years)			
Copy of Medicaid card (If applicable)			
Level of Care Determination (If waiver enrolled)			
Notice of Decision (NOD) (if waiver enrolled)			
Documentation of Choice			
Application of Services			
Psychiatric Consult (Only if applicant is diagnosed with a psychiatric condition)			

If you have any questions about Life's WORC services and supports or should you have any questions regarding this application or the intake process please contact the Life's WORC Intake Department at: 516-741-9000 ext. 470 or 271. Thank you



APPLICATION FOR SERVICES

Life's WORC, INC
 1501 Franklin Avenue
 Garden City, NY 11530-5560
 Phone: 516-741-9000 Fax: 516-741-5560
 Website: www.lifesworc.org

APPLICANT'S NAME: _____

Date: _____

SELECT PROGRAM OF INTEREST

Queens Programs

Check all that apply

		Indicate when you would be interested in this program: i.e., Now, Within 2 years, 5+ years
<input type="checkbox"/>	RESIDENTIAL PPD Required Ages 18+, Ambulatory or Non Ambulatory setting	
<input type="checkbox"/>	MEDICAID SERVICE COORDINATION Children & Adults	
<input type="checkbox"/>	AT HOME RESIDENTIAL HABILITATION 1:1 support in your home, ages 3+ Must have Medicaid and be waiver enrolled	
<input type="checkbox"/>	WEEKEND RECREATION [Children & Adults] Ambulatory and Non ambulatory, Must have Medicaid and be Waiver enrolled, Community based trips, 11am-4pm	
<input type="checkbox"/>	DAY HABILITATION PPD Required Glendale & Queens Village Ages 18+ and Ambulatory	
<input type="checkbox"/>	STEPPING INTO ADULTHOOD PPD Required Glendale, Ages 15-20, after school and Saturday life skills program for people with MR & Autism	

Long Island Programs

Check all that apply

		Indicate when you would be interested in this program: i.e., Now, Within 2 years, 5+ years
<input type="checkbox"/>	RESIDENTIAL PPD Required Ages 18+, Ambulatory or Non Ambulatory setting	
<input type="checkbox"/>	MEDICAID SERVICE COORDINATION Children & Adults	
<input type="checkbox"/>	AT HOME RESIDENTIAL HABILITATION 1:1 support in your home, ages 3+ Must have Medicaid and be waiver enrolled	
<input type="checkbox"/>	RECREATION (Saturdays) Ages 13+, ambulatory, 18+ must have Medicaid and be Waiver enrolled, no transportation available	
<input type="checkbox"/>	DAY HABILITATION PPD Required Garden City, Old Bethpage, E. Rockaway & Deer Park Transitioning from High School, Ambulatory	
<input type="checkbox"/>	CREATIVE ARTS & MUSIC THERAPY PPD Required Garden City, after school & Saturdays, ages 3-12, Must have Medicaid and be waiver enrolled or private pay	
<input type="checkbox"/>	MAKING CONNECTIONS SOCIALIZATION PROGRAM Bayshore & Glen Cove, ages 5-12, Saturdays For children with autism, \$150 Registration fee	

How did you hear about Life's WORC? (Please be specific) _____

What services not currently offered by Life's WORC would the applicant be interested in?



APPLICANT INFORMATION

NAME: _____

Gender: Male Female

Date of Birth: _____

Social Security #: _____

Medicaid #: _____

Medicare #: _____

Other Medical Insurance: _____

Insurance ID #: _____

Medicaid Waiver Enrolled? Yes No Pending

TABS #: _____

Applicants Current Address: _____

Home Telephone: _____ Cell #: _____

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

Days

Scheduled: _____

Scheduled: _____

Does the applicant have a non-drivers ID card?

Yes (attach copy)

No

Does the applicant have a passport?

Yes

No

Does applicant have a Medicaid Service Coordinator?

Yes*

No

*Name of Medicaid Service Coordinator: _____ Tel # _____

Agency Name: _____

Address: _____

Does the applicant currently receive services in his/her home? Yes* No

* If yes, specify below type of service and frequency (i.e. nursing, physical therapy, residential habilitation)


MEDICAL INFORMATION
CHECK ALL THAT APPLY

- Mental Retardation:** Mild Moderate Severe Profound
 Cerebral Palsy
 Autism
 PDD NOS (Pervasive Developmental Disability, Non Specified)
 Aspergers Syndrome
 Learning Disability
 Dually Diagnosed (Mental Retardation AND a Psychiatric Diagnosis) _____
 Other (Please specify): _____

MEDICAL CONDITIONS

Respiratory (e.g. asthma, emphysema, cystic fibrosis)	<input type="checkbox"/> No	<input type="checkbox"/> Yes, specify:
Cardiovascular (e.g. heart disease, high blood pressure)	<input type="checkbox"/> No	<input type="checkbox"/> Yes, specify:
Gastro-Intestinal (e.g. ulcers, colitis, liver and bowel difficulties)	<input type="checkbox"/> No	<input type="checkbox"/> Yes, specify:
Genito- Urinary (e.g. kidney problems)	<input type="checkbox"/> No	<input type="checkbox"/> Yes, specify:
Endocrine (e.g. diabetes, thyroid conditions)	<input type="checkbox"/> No	<input type="checkbox"/> Yes, specify:
Neoplastic Disease (e.g. cancer, tumors)	<input type="checkbox"/> No	<input type="checkbox"/> Yes, specify:
Neurological Diseases (e.g. MS, organic brain syndrome, ALS, Huntington's disease)	<input type="checkbox"/> No	<input type="checkbox"/> Yes, specify:
Psychiatric (e.g. anxiety, depression)	<input type="checkbox"/> No	<input type="checkbox"/> Yes, specify:
Allergies (e.g. foods, environmental)	<input type="checkbox"/> No	<input type="checkbox"/> Yes, specify:
Special Diet (e.g. gluten free)	<input type="checkbox"/> No	<input type="checkbox"/> Yes, specify:
Does the applicant use a feeding tube ?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, specify:
Does the applicant have a colostomy?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, specify:
Does the applicant use a CPAP machine?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, specify:
Does the applicant require oxygen?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, specify:
Does the applicant require suctioning?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, specify:
Does the applicant have a history of seizures? (i.e., grand mal or petit mal and frequency of seizure)	<input type="checkbox"/> No	<input type="checkbox"/> Yes, specify:
Is the applicant obese?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, specify current height _____ Current weight _____

MEDICATIONS

 (List all medications)

Medication	Dosage	Frequency	Indication for Use



PHYSICIAN INFORMATION

Primary Care Physician's Name: _____ Tel #: _____

Address: _____

COMMUNICATION

Primary Language Spoken by Applicant: _____

Check the response that best describes the applicants method of communication

- Speaks
- Uses signs or communication device (i.e., Dynavox, PECS)
- Uses gestures, vocalizations
- Unable to communicate

BEHAVIOR

Does the applicant exhibit any of the following behaviors? (Check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Temper Tantrums | <input type="checkbox"/> Physical Aggression |
| <input type="checkbox"/> Wandering / Elopment | <input type="checkbox"/> Self Abuse |
| <input type="checkbox"/> Verbal Aggression | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Sexually Inappropriate Behavior | <input type="checkbox"/> Eats inedible objects |
| | <input type="checkbox"/> Other, specify _____ |

Is applicant taking medication for any of the above behaviors/symptoms? Yes No

If applicant is prescribed medication to address symptoms related to a psychiatric diagnosis or maladaptive behaviors, please list the name of the prescribing psychiatrist and contact information :

Physician Name: _____ Tel#: _____

Address: _____

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



SENSORY SKILLS

Which best describes the applicant's **hearing**? Normal Mild/Moderate loss Severe loss/Profound loss
 Does the applicant use a hearing aid? Yes No

Which best describes the applicant's **vision**? Fully Sighted Moderate impairment Severe impairment Total blindness
 Does the applicant use glasses? Yes No

MOTOR SKILLS

Please check the best response that describes the applicant's level of mobility

- Walks independently Walks independently but with difficulty Can not walk
- Walks with a corrective and /or adaptive device (i.e., walker, cane, braces)
 (Specify) _____
- Uses a wheelchair (*Specify type: manual, power or both) _____

***Check the response that best describes applicant's wheelchair mobility**

- Self propels and transfers independently
- Self propels but cannot transfer independently
- Requires assistance in transferring and moving
- No mobility (Must be transferred and moved)

ADAPTIVE EQUIPMENT

(Check all equipment which applicant currently uses) None

<input type="checkbox"/> Egg crate mattress pad	<input type="checkbox"/> Hand held shower head	<input type="checkbox"/> Hospital Bed	<input type="checkbox"/> Portable commode	<input type="checkbox"/> Raised toilet seat	<input type="checkbox"/> Shower chair
<input type="checkbox"/> Toilet seat rails	<input type="checkbox"/> Tub rail	<input type="checkbox"/> Bed rails	<input type="checkbox"/> Eating equipment, (Specify)		
<input type="checkbox"/> Other, Specify					

Please indicate any other special accommodations that applicant needs (i.e., intercom, specialized furniture, etc.)



SELF CARE: DAILY LIVING SKILLS

Please describe how independently the applicant performs the following by placing an **X** in the appropriate box

	TOTAL SUPPORT	ASSISTANCE	SUPERVISION	INDEPENDENT
Toileting/bowels	Diaper? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Toileting/bladder	Diaper ? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Taking a shower/bath				
Brushing teeth (dentures?)				
Brushing/combing hair				
Selecting weather appropriate clothes				
Putting on clothes				
Undressing self				
Pouring liquids				
Drinking from a cup or glass				
Chewing and swallowing food				
Setting the table				
Feeding self				
Making bed				
Cleaning room				
Doing laundry				
Using telephone				
Shopping for a simple meal				
Preparing foods that do not require cooking				
Using a stove or microwave				
Crossing street in residential neighborhood				
Using public transportation for a simple trip				
Managing own money				
Taking medication				

Additional Comments:



FAMILY INFORMATION

Mother's Name: _____

Home #: _____ **Work #:** _____ **Cell #:** _____

Address: _____

E-mail address: _____

Father's Name: _____

Home #: _____ **Work #:** _____ **Cell #:** _____

Address: _____

E-mail address: _____

Other Primary Care Giver Name: _____

Relationship to applicant: _____

Home #: _____ **Work #:** _____ **Cell #:** _____

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

Does the applicant have a court appointed legal guardian? Yes No

Name: _____

Emergency Contact Details:

Name: _____ Relationship: _____

Phone # : _____

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 or revocation of acceptance into the Life's WORC program.

Signature of the person completing this application: _____ **Date** _____

Relationship to applicant: _____



TUBERCULOSIS TESTING REQUIREMENTS
Effective June 1, 2010

As per NYS Regulations (Section 633.14), “Procedures for the Control of Tuberculosis” a 2-Step PPD is now mandatory for all new individuals seeking services from OMRDD certified site.

Program(s) Requiring A PPD are as follows:

Residential, Day Habilitation, Stepping into Adulthood, Creative Arts & Music Therapy

HOW TO MEET THIS REQUIREMENT:

PPD Status	Requirements
Two (2) consecutive negative PPD’s and the second PPD is current (within the last 365 days)	Meet the requirement and do not need further testing
One (1) current PPD (within the last 365 days)	Need One (1) more PPD within 365 days from the 1 st PPD date
Individual does not have either of the above	Individual will be required to have 2 step PPD testing or a QuantiFerion TB Gold blood test

Individuals excluded from PPD testing:

- Individuals who have a prior documented significant reaction to TB testing.
- Individuals who have received adequate treatment for active pulmonary tuberculosis.
- Individuals who have completed adequate prevention therapy.

Individuals **excluded** from PPD testing are required to provide a statement from their medical provider that includes:

- a) A recommendation as to when and if testing would be appropriate at designated point in the future; and
- b) How the individual will be evaluated for active pulmonary tuberculosis in the interim

ONCE THIS REQUIREMENT HAS BEEN MET, ANNUAL PPD TESTING IS NO LONGER REQUIRED

Frequently Asked Questions

What is a PPD?	A PPD is a test to determine if a person has been exposed to or has an active case of tuberculosis (TB). It is a skin test and NOT a vaccine. A small amount of PPD (Purified Protein Derivative) is placed under the top layer of the skin. If a skin reaction occurs at the site 48-72 hours later than the test is considered positive for exposure or active disease.
What is a Purified Protein Derivative?	It is a cell free, purified protein obtained from a strain of TB. It does not contain any TB cells.
Does it contain Thimerosal?	No, PPD (also called Mantoux and Tubersol) does not contain Thimerosal.
Why do I need another PPD if my 1st one is negative?	As per the CDC, 2 step PPD testing is required to minimize the likelihood of confusing a reaction from an old infection (boosting) with a reaction to a recent infection (conversion).



RELEASE OF INFORMATION FORM

I hereby give my consent for information on: _____

to be released from the hospital or clinic records of:

and mailed or faxed to:

**Life's WORC
1501 Franklin Avenue
P.O. Box 8165
Garden City, NY 11530-8165
Fax: 516-741-5560**

(Applicant/Parent/Guardian *Signature*)

(Date)

(Print Name)

(Relationship)

(Address)

(Tel #)

THIS DOCUMENT MUST BE MADE PART OF THE INDIVIDUAL'S RECORD