



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/ IED (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)			
Eligibility Notice			

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 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)

<input type="checkbox"/>	RESIDENTIAL Ages 18+, Ambulatory or Non Ambulatory setting. IRAs	PPD Required	
<input type="checkbox"/>	MEDICAID SERVICE COORDINATION Children & Adults		
<input type="checkbox"/>	COMMUNITY HABILITATION 1:1 support in your home, Ages 3+ Must have Medicaid and be waiver enrolled		Please indicate what skill(s) need enhancement.
<input type="checkbox"/>	WEEKEND RECREATION [Children (Ages 5 –15) & Adults (Ages 16+)] Ambulatory and Non ambulatory, Must have Medicaid and be Waiver enrolled, Community based trips, 11 am–4pm		
<input type="checkbox"/>	DAY HABILITATION Glendale & Queens Village Ages 18+ and Ambulatory	PPD Required	Note: No transportation Available for trials
<input type="checkbox"/>	STEPPING INTO ADULTHOOD Glendale, Ages 15–20, after school and Saturday life skills program for people with MR & Autism	PPD Required	
<input type="checkbox"/>	BEHAVIOR SUPPORT PROGRAM Home based, Ages 5–13 with Autism and Behavioral concerns		

Long Island Programs

(Check all that apply)

<input type="checkbox"/>	RESIDENTIAL Ages 18+, Ambulatory or Non Ambulatory setting	PPD Required	
<input type="checkbox"/>	MEDICAID SERVICE COORDINATION Children & Adults		
<input type="checkbox"/>	COMMUNITY HABILITATION 1:1 support in your home, Ages 3+ Must have Medicaid and be waiver enrolled		Please indicate what skill(s) need enhancement.
<input type="checkbox"/>	RECREATION (Saturdays) Ages 16+, ambulatory, 18+ must have Medicaid and be Waiver enrolled, no transportation available		
<input type="checkbox"/>	DAY HABILITATION Garden City, Old Bethpage, E. Rockaway & Deer Park Transitioning from High School, Ambulatory	PPD Required	Note: No transportation Available for trials
<input type="checkbox"/>	CREATIVE ARTS & MUSIC THERAPY Garden City, after school & Saturdays, Ages 3–15, 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, specify) _____

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 #:** _____

E-Mail Address: _____

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: _____

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: _____

E-mail _____

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, community habilitation, home health aide, behavior intervention)

Does applicant receive any other OPWDD Services from another agency ? Yes*, please specify No

*Specify type of service, frequency and agency name _____



MEDICAL INFORMATION

CHECK ALL THAT APPLY

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

MEDICAL CONDITIONS

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

MEDICATIONS

(List all medications)

Medication	Dosage	Frequency	Indication for Use



PHYSICIAN INFORMATION

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

Fax #: _____

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)

- | | |
|---------------------------------|-----------------------|
| Temper Tantrums | Physical Aggression |
| Wandering / Elopment | Self Abuse |
| Verbal Aggression | Anxiety |
| Hyperactivity | Depression |
| Sexually Inappropriate Behavior | Eats inedible objects |
| | 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?) Please be specific.

Does the applicant have a Behavior Intervention plan that addresses any of the above noted symptoms or behaviors ? If yes, please attach a copy.



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

Egg crate mattress pad	Hand held shower head	Hospital Bed	Portable commode	Raised toilet seat	Shower chair
Toilet seat rails	Tub rail	Bed rails	Eating equipment, (Specify)		
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? Yes No			
Toileting/bladder	Diaper ? Yes No			
Taking a shower/bath				
Brushing teeth (dentures?)				
Drinking from a cup or glass				
Chewing and swallowing food				
Feeding self				
Using telephone				
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 # : _____ Cell #: _____

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 Life's WORC program, Services or Supports.

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 pertaining to: _____
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