Life's WORC
Living With Dignity. Growing With Pride.

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 Care Manager 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: _____

TABS # (If known) _____

Document	**√ Document attached**	FOR LIFE"S WORC USE ONLY	
		Document Accepted	Document Required
Annual Physical Exam with PPD * (See attached guidelines)			
Annual ISP/ IEP/ Life Plan (if applicant receives CCO services) Note: ISP Addendum must be submitted once applicant is accepted into a program			
Psycho-Social Evaluation (Must be within 3 years)			
Psychological Evaluation (Must be within 3 years)			
Copy of Medicaid card (If applicable)			
Application for Waiver Services			
Eligibility Notice: NYS OPWDD Front Door Approval Letter			
For Employment Services, please include: : Access VR Denial Letter : Copy of Drivers' License or Non-Drivers License ID : Copy of Social Security Card or Copy of Birth Certificate : Copy of LOC (Level of Care Determination)			

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. 8120 or 8130. Thank you

SELECT PROGRAM OF INTEREST

Queens Programs

(Check all that apply)

- ☐ **RESIDENTIAL** — **PPD Required**
  Ages 18+, Ambulatory or Non Ambulatory IRAs
- ☐ **MEDICAID SERVICE COORDINATION**
  Children & Adults
- ☐ **COMMUNITY HABILITATION**
  1:1 support in your home, Children & Adults
  Must have Medicaid and be waiver enrolled
  - ☐ **ISS** (Individual Support Services)
  - ☐ **FET**(Family Education & Training)
  - ☐ **FSS** (non-mediicaid Comm Hab)
- ☐ **WEEKEND RECREATION**
  [Children (Ages 6 -13) Teens (Ages 14-20) & Adults (Ages 21+)]
  Ambulatory, Must have Medicaid and be Waiver enrolled,
  Community based trips, 11am-4pm
  - ☐ **Non-medicaid weekend Rec**
- ☐ **DAY HABILITATION** — **PPD Required**
  Glendale & Queens Village
  Ages 18+ and Ambulatory
  Note: No transportation Available for trials
- ☐ **STEPPING INTO ADULTHOOD** — **PPD Required**
  Glendale, Ages 14-20, after school and Saturday
  life skills program for people with ID & Autism
  Note: No transportation Available
- ☐ **BEHAVIOR SUPPORT PROGRAM**
  Home based, Ages 5-13 with Autism and Behavioral concerns
- ☐ **EMPLOYMENT SERVICES**
  Ages 18+, Waiver enrolled.
- ☐ **SUPPORT BROKER**
  (For individuals with Self-Directed plans)

Long Island Programs

(Check all that apply)

- ☐ **RESIDENTIAL** — **PPD Required**
  Ages 18+, Ambulatory or Non Ambulatory IRA's
- ☐ **MEDICAID SERVICE COORDINATION**
  Children & Adults
- ☐ **COMMUNITY HABILITATION**
  1:1 support in your home, Children & Adults
  Must have Medicaid and be waiver enrolled
  - ☐ **ISS** (Individual Support Services)
  - ☐ **FET**(Family Education & Training)
  - ☐ **FSS** (non-mediicaid Comm Hab)
- ☐ **RECREATION (Saturdays)**
  Ages 16+, ambulatory, 18+ must have Medicaid and be Waiver enrolled,
  no transportation available
- ☐ **DAY HABILITATION** — **PPD Required**
  Garden City, Old Bethpage, E. Rockaway & Deer Park
  Age 18+, full or part-time
  Note: No transportation Available for trials
- ☐ **CREATIVE ARTS & MUSIC THERAPY**
  Garden City, after school & Saturdays, Ages 3-15,
  Must have Medicaid and be waiver enrolled or private pay
- ☐ **MAKING CONNECTIONS SOCIALIZATION PROGRAM**
  Bayshore & Garden City, Ages 5-12, Saturdays
  For children with autism, $150 Registration fee
- ☐ **EMPLOYMENT SERVICES**
  Ages 18+, Waiver enrolled.
- ☐ **SUPPORT BROKER**
  (For Individuals with Self-Directed Plans)

NYC Programs

- ☐ **RESIDENTIAL** — **PPD Required**
  Ages 18+ Ambulatory or Non Ambulatory IRA's

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

APPLICANT INFORMATION

NAME: _____ **Gender**: ☐ Male ☐ Female

Date of Birth: _____ **Social Security #**: _____

Medicaid #: _____ **Medicare #**: _____

Medicaid Waiver Enrolled? ☐ Yes ☐ No ☐ Pending **"Front Door" completed?** ☐ Yes ☐ No ☐ Pending

Applicants Current Address: _____

Home Telephone: _____ Cell #: _____

E-Mail Address: _____

Applicant's Current Day Activity

(Check all that apply)

☐ **School** (graduation year _____)

School Name

_____

Tel # _____

☐ **Day Program**

☐ **Day Hab w/o walls**

☐ **Site-based Day Hab program**

Program Name

_____

Tel # _____

Days Scheduled:_____

☐ **Employment**

Employer

_____

Tel # _____

Days Scheduled: _____

Do You Have a Job Coach ☐ Yes ☐ No

*Name of Agency_____

Applicant's Current Services

Does applicant have a Care Manager? ☐ Yes* ☐ No

Name of Care Coordination Organization _____ **Tel #** _____

Name of Care Manager: _____

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_____

Does the applicant have a Self-directed Plan? ☐ Yes*, please specify ☐ No

***Support Broker Name & Telephone #**_____

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: _____

Phone#: _____

Emergency Contact Details:

Name: _____ Relationship: _____

Phone #: _____ Cell #: _____

DIAGNOSTIC INFORMATION

CHECK ALL THAT APPLY

Intellectual Disability: ☐ Mild ☐ Moderate ☐ Severe ☐ Profound

☐ **Cerebral Palsy** ☐ **Down's Syndrome**

☐ **Autism** ☐ **Aspergers Syndrome**

☐ **PDD NOS** (Pervasive Developmental Disability, Non Specified)

☐ **Learning Disability**

☐ **Dually Diagnosed** (Intellectual Disability & a Psychiatric Diagnosis) (Please specify): _____

☐ **Traumatic Brain Injury** (prior to age 22)

☐ 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_____**

CURRENT MEDICATIONS

(List all medications)

Medication	Indication for Use

COMMUNICATION

Primary Language Spoken/Understood by Applicant: _____

Check the response that best describes the applicants' method of communication

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

BEHAVIOR PROFILE

☐ **Does not exhibit any of the below noted behaviors**

The applicant exhibits the following behaviors. (Check all that apply)
Indicate frequency: 1= daily 2 = weekly 3 = monthly 4 = @3 months 5 = @ 6 months

- ☐ Temper Tantrums _____
- ☐ Wandering / Elopement _____
- ☐ Verbal Aggression _____
- ☐ Hyperactivity _____
- ☐ Sexually Inappropriate Behavior _____
- ☐ Physical Aggression _____
- ☐ Self Abuse _____
- ☐ Anxiety _____
- ☐ Depression _____
- ☐ 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 eye 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

Does the applicant use any Adaptive Equipment? ☐ Yes* (please specify) ☐ No

*_____
_____
_____
_____
_____

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:

_____

_____

_____

_____

_____

_____

_____

TUBERCULOSIS TESTING REQUIREMENTS

Effective June 1, 2010
Program(s) requiring a PPD are as follows:
Residential, Day Habilitation, Stepping into Adulthood

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 OPWDD certified programs.

Program(s) requiring a PPD are as follows:
Residential, Day Habilitation, Stepping into Adulthood

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 1st 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).

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

Should the applicant be accepted into a Life's WORC program, you will be required to submit additional documentation in order to complete the enrollment process.

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 applicants' non-acceptance or revocation of acceptance into Life's WORC program, services or supports.

Signature of applicant: _____ _____
Date

Signature of the person completing this application: _____ _____
Date

Relationship to applicant: _____