Date of Application: _____

Initial Application for New Participants

Recreation and Respite Services

INSTRUCTIONS: Please fully complete the entire application and return it by email or USPS with the supporting documentation. Incomplete applications will be returned. Enrollment into any program will not proceed until all of the materials are received and reviewed, an intake interview is completed, and the necessary OPWDD and Arc Westchester approvals are also completed.

Services Desired: (check all that apply)
Daycation/Day Trips ☐ **Weekend Overnight Trips** ☐ **Arc Theater** ☐
Gateway Program (Arc Westchester Choices only) ☐ **Summer weeklong trips** ☐
Summer Enrichment Program @ Manhattanville ☐ **Echo on Stage @WCC (summer)** ☐
Free Standing Respite House-Thornwood ☐

Applicant: _____ Nickname: _____

Date of Birth: ____/_____/_____ Age: _____ Male: ☐ Female ☐

Social Security#: _____ OPWDD Tabs #, if known_____

Medicaid #: _____ Medicare #: _____

Medical Insurance Company: _____ Policy #: _____

*Attach copies of Medicaid/ Medicare or Insurance card (both front and back) *

Home Address: _____

Mailing address if different from above: _____

Applicant cell phone: _____ Applicant email: _____

Religion: ☐ Baptist ☐ Buddhist ☐ Catholic ☐ Christian ☐ Hindu ☐ Jehovah's Witness

☐ Jewish ☐ Lutheran ☐ Methodist ☐ Mormon ☐ Muslim ☐ None

☐ Pentecostal☐ Refused Disclosure ☐ Unknown ☐ Wicca

Ethnicity: ☐ Black ☐ Hispanic ☐ Native American ☐ Pacific Islander or Asian
☐ White ☐ Other

OPWDD eligible? Yes ☐ No ☐ OPWDD Waiver Eligible? Yes ☐ No ☐

Parent/ Guardian Contact Information

Legal Guardian: _____ Relationship: _____

* Attach copy of decree (adults with guardianship only)

Parents: Married ☐ Separated ☐ Divorced ☐

Parent Name: _____ Relationship: _____

Home Phone #: _____ Work Phone #: _____

Cell Phone #: _____ Email: _____

Parent Name: _____ Relationship: _____

Home Phone #: _____ Work Phone #: _____

Cell Phone #: _____ Email: _____

In Case of Emergency (Other than parent/guardian)

Name **Relationship** **Telephone #**

_____

_____

Current School, Day Service or Employer

Name of school/agency/employer: _____

Address: _____

Contact Person: _____ Telephone #: _____

Transportation provided by: _____

Contact Person: _____ Telephone #: _____

Paratransit ID # (if applicable): _____

Please list any other agencies or services received (including Care Management, Respite services…)

Service	Agency	Contact Person/ Number/ Email
1. Care Management		
2.		
3.		
4.		

Medical Information

Primary Doctor: _____ Telephone: _____

Dentist: _____ Telephone: _____

Additional Specialists:

Name	Specialty	Contact #

Applicant's Developmental Diagnoses:

Primary Developmental Diagnosis: _____

Secondary Developmental Diagnosis: _____

Applicant's Medical Diagnoses:

_____

_____

_____

Applicant's Psychiatric Diagnoses: None: ☐

_____

_____

_____

Can he/she self-administer medication? Yes ☐ No ☐

Precautions: (check all that apply, or write in other precaution)

☐ SBE ☐ Aspiration ☐ Seizure ☐ Other: _____

☐ Hepatitis Hepatitis Immune: ☐ Yes ☐ No Hepatitis Carrier: ☐ Yes ☐ No

Other communicable diseases? ☐ Yes ☐ No If yes, please specify: _____

_____

Date of last tetanus shot: _____

A two-step PPD/TB test is required. Quantiferon testing is also acceptable

PPD #1 Date: _____ PPD Results: _____(induration in mm)

PPD #2 Date: _____ PPD Results: _____ (induration in mm)

Quantiferon Date: _____ Results: _____

If applicable, Chest x-ray date: _____ Chest x-ray results: _____

Attach immunization record if available

Does he/she take any prescription or Over The Counter medication? Yes* ☐ No ☐

****If yes- a doctor's order for prescriptions and the Over the Counter Medication Administration form(the OTC form is only for Free Standing Respite House and the Summer programs) must be submitted annually or as changes occur****

List all medications below (prescription and Over the Counter)

Medication	Dosage	Times Given	Purpose

Is the applicant able to walk: Independently ☐ With assistance ☐ Requires equipment: ☐

History of falls: Yes ☐ No ☐

Describe assistance needed: _____

_____

Does he/she use any adaptive equipment (ex: cane, walker, wheelchair)? Yes ☐ No ☐

If yes, please explain _____

Does he/she have any vision impairment? Yes ☐ No ☐

_____

Are glasses/contacts needed? Yes ☐ No ☐

Does he/she have any hearing impairment? Yes ☐ No ☐

_____

Is a hearing aid used: Yes ☐ No ☐

Does applicant have a seizure disorder? Yes☐ No ☐

If so, describe type, usual length and frequency:

_____

_____

Are there any known triggers or aura's? Yes ☐ No ☐

If yes, please describe: _____

_____

Assistance provided after a seizure: _____

_____

Does applicant have food, medication, or seasonal allergies? Yes ☐ No ☐

If yes list allergies

(food/medication/environmental):_____

_____

If yes, please list and indicate usual reaction/treatment if exposed to allergen:

_____

Does applicant require an EpiPen? Yes☐ No ☐

If yes, do they carry it or require staff to? _____

Please list any recent hospitalizations (in past 2 years)

Hospital	Length of Stay (days)	Reason

Daily living skills

	Independent	Needs Assistance	If assistance needed describe
Toileting:	☐	☐	_____
Bathing:	☐	☐	_____
Shaving:	☐	☐	_____
Dressing:	☐	☐	_____
Tooth brushing:	☐	☐	_____
Hair Care:	☐	☐	_____
Menstrual (if applicable):	☐	☐	_____
Travel skills:	☐	☐	_____
Money management:	☐	☐	_____

Communication/Social Skills/Behavior

Primary Language spoken/understood: _____

Describe applicant's communication skills:

	Excellent	Good	Fair	Poor
Receptive:	☐	☐	☐	☐
Expressive:	☐	☐	☐	☐

Any Communication devices used? Yes ☐ No ☐ (ex: iPad or other text to speech devices)

_____

If nonverbal, does he/she use gestures? Yes ☐ No ☐ Sign language? Yes ☐ No ☐

Does applicant have any fears or things that make him/her upset? (ex: balloons, animals, water, thunder, fire)

_____

_____

Does the applicant have any behavior issues (physical aggression/verbal outburst/elopement/wandering/self-injurious, property destruction, repetitive behaviors, inappropriate sexual behavior)? Yes ☐ No ☐

If yes, please describe behavior and approaches that help to calm applicant _____

_____

_____

Describe applicant's ability to interact socially: _____

_____

_____

Please list applicant's favorite activities? _____

_____

_____

Nutrition

Special diet/restrictions: Yes ☐ No ☐ History of choking: Yes ☐ No ☐

Special Diet (check all that apply):

☐ Regular	☐ Weight Maintenance	☐ Weight Gaining	
☐ Weight Reduction	☐ Low Fat	☐ Low Sodium	☐ 1500 calorie
☐ 1800 calorie	☐ ADA diet	☐ Low concentrated sweets	☐ No concentrated sweets
☐ High fiber	☐ Pureed	☐ Ground	☐ Cut into ¼ inch pieces
☐ Cut into ½ pieces	☐ Cut into 1" pieces		☐ PKU
☐ No spices	☐ No grease	☐ No aspartame/Nutra Sweet	
☐ Gluten Free	☐ Paleo Diet	☐ Lactose Free	☐ Low/No Carb

Food restrictions: _____

Favorite foods: _____ Disliked foods: _____

Does he/she need a packed lunch each day? Yes ☐ No ☐

If yes, please list any special instructions_____

Sleeping

Does applicant sleep thru the night? Yes ☐ No ☐

Applicant's usual waking time: _____ Bedtime: _____.

Does the applicant have a specific bedtime routine? (ex: nightlight, special item, or book)

_____

_____

Has the applicant ever slept away from home? Yes ☐ No ☐

Is there anything else we should know about the applicant?

_____

_____

_____

_____

_____

_____

_____

_____

Completed by: _____ Date: _____

Relationship to participant: _____

****Application is valid for 1 year from the date above ****

INITIAL APPLICATION MUST BE RETURNED TO:

Ms. Crystal Johnson
The Arc Westchester
265 Saw Mill River Road
Hawthorne, New York 10532
Email: cjohnson@arcwestchester.org

Received and reviewed by Arc staff: _____ Date:_____