Date of Application: : __/__/____ Name of Applicant: _____

Aspire of WNY Referral Form for OPWDD Waiver Services

One-of-a-kind services for one-of-a-kind people.

DOB: __/___/_____ Tabs #: _____ Gender:_____ SSN#: ___-___-_____

Applicant Primary Phone Number: ____-____-_____ Secondary: ____-____-_____

Applicant Address: _____

Applicant Email:_____

Medicaid #: _____Medicare # (if applicable):_____ Primary Language: _____

Do you have private/3rd party insurance? Yes ☐ No ☐ If yes, please provide the following:

Company/Plan Name _____ Insured_____

ID # _____ Group Number _____

Parent/Legal Guardian/Advocate	**Phone Number** (if different than applicant)	**Email Address** (if different than applicant)

Care Coordinator (CC) Name: _____ CCO (check one): ☐Person Centered Services CC

CC Phone #:____-____-_____ ☐ Prime Care

CC Email: _____

Services Requested: (Please check all that apply)

Habilitation Services:	**Respite:**	**Vocational:**
☐ Day Habilitation (Site-Based)	☐ In Home Respite	☐ Community Based Prevocational Service: Adult Development &Professional Training (ADAPT)
☐ Supported Volunteering & Life Enrichment Program (SVLEP)	☐ Direct Provider Purchased	☐ Pathways to Employment: Making Opportunities Via Vocational Experience (MOVE)
☐ Aspire's CoOp	☐ Agency-Supported Self-Directed	☐ OPWDD Supported Employment
☐ Technology Today	☐ Freestanding Respite	**Support Services:**
Community Habilitation	☐ After School Respite	☐ Family Education & Training (FET)
☐ Direct Provider Purchased	☐ Saturday Respite	☐ Environmental Modification (EMOD)
☐ Agency-Supported Self-Directed	**Self-Directed Services:**	☐ Vehicle Modification (VMOD)
☐ Residential	☐ Fiscal Intermediary and Support Broker	☐ Adaptive Technology
☐ Residential Habilitation*	☐ Fiscal Intermediary (only)	**Educational Services:**
Health Center Services:	☐ Support Broker (only)	☐ Day Care/Early Intervention Services
☐ Primary Care	☐ Self-Hire Community Habilitation	☐ Pre-school Services
☐ Therapy Services	☐ Self-Hire Respite	☐ School-aged Services

***Please note: All requests and inquiries for Residential Habilitation must follow the OPWDD Certified Residential Opportunities (CRO) Process*- for more information, please call OPWDD at (800) 487-6310.**

****Please note: By checking boxes for Health Center Services or Educational Services, a copy of this packet will be provided to Aspire's Health Care Center and/or Aspire's Center for Learning; additional paperwork may be required.**

Date of Application: : __/__/____ Name of Applicant: _____

Is applicant enrolled in HCBS Waiver: ☐ Y ☐ N ☐ Pending- Date of submission to DDRO: _____
For Day Habilitation requests only, date of graduation: _____
Justification for referral: (Describe situation, use additional paper if needed) _____

_____
_____
_____
_____
_____
_____
_____
_____
_____

Developmental Disabilities

Intellectual Disability: (Select One) ☐Mild ☐Moderate ☐Severe ☐Profound ☐Undetermined
☐Cerebral Palsy ☐Epilepsy/Seizure Disorder ☐Autism ☐Neurological Impairment
Does this individual have a Psychiatric Diagnosis? Yes ☐ No ☐ If yes, please list:_____
Verbal ☐ Non-verbal ☐ Communication methods (if any): _____
Ambulatory ☐ Non-ambulatory ☐ Explain any needed mobility supports:_____
_____
Please list all medical diagnoses: _____
_____

Does applicant have any known allergies? Y ☐ N ☐ If yes, please list allergy, typical reaction, treatment:

_____
_____

Levels of Care/Supervision

Describe level of care/supervision required AT HOME: _____
Describe level of care/supervision required IN THE COMMUNITY: _____
Describe level of care/supervision required OTHER (please specify in description): _____
_____

Available Transportation (please check all that apply)

Own Car ☐ Family Provided ☐ Medicaid Transportation ☐Paratransit ☐Other: _____

Personal Care	**Independent**	**Needs Help**	**Dependent**
Toileting			
Urination	☐	☐	☐
Bowels	☐	☐	☐
Transfers while toileting	☐	☐	☐
Wash hands	☐	☐	☐
Dressing	☐	☐	☐
Undressing	☐	☐	☐
Tub/Shower	☐	☐	☐
Wash body	☐	☐	☐
Wash hair	☐	☐	☐
Comb hair	☐	☐	☐
Brush teeth	☐	☐	☐

Date of Application: : __/__/____ Name of Applicant: _____

Menstruation Care	☐	☐	☐
Mealtime			
Eats	☐	☐	☐
Drinks	☐	☐	☐
Cuts food	☐	☐	☐
Cleans self	☐	☐	☐
Medication Administration	☐	☐	☐

Wears briefs/diapers: Yes ☐ No ☐
Adaptive equipment for toileting: Yes ☐ No ☐
G-Tube Fed: Yes ☐ No ☐
Adaptive equipment for feeding: Yes ☐ No ☐
Are there any dietary orders, special diet, supports needed during feeding, please list: _____
_____

Behavior *(*If the individual has a current behavior plan, it will be required with this application.)*
Does this individual have a behavior management program or plan at: Home ☐ School ☐ Day Program ☐ None ☐
Please check all behaviors that are addressed in their plan: Wanders/elopes ☐ Destruction of property ☐ Physical aggression towards staff ☐ Physical aggression towards peers ☐ Sexually inappropriate behavior ☐ Non-compliance ☐ Screams/swears/verbal aggression ☐ Self-injurious behavior ☐ Biting ☐ Urination/defecation ☐

What strategies have been attempted to address these behaviors? _____
_____
Are there strategies/techniques that have been especially effective? Please describe. _____
_____
Please describe any other important information or history regarding behaviors: _____
_____
_____
Is this individual sexually-consenting? Y☐ N ☐ Has not been evaluated ☐
Is this person under Psychiatric Care? Y ☐ N ☐
If yes, name of provider(s): _____
Medications prescribed to treat behaviors: _____
_____

List all current OPWDD and non-OPWDD (CCO, DSS, CASA, OMH) **services being received:**

Service	Provider Name	Provider Contact Name	Provider Contact Phone #

Date of Application: : __/__/____ Name of Applicant: _____

The following documents must be received by Aspire of WNY's Central Intake Department in order for referral packet to move out of intake for program review:

- **Aspire of WNY Referral Form for OPWDD Waiver Services**
- **Life Plan (*or ISP through 12/31/19*)**
- **HCBS Waiver Notice of Decision (NOD)**
- **Current Level of Care Eligibility Determination (LCED)**
- **Front Door Authorization Letter or Service Amendment Form (SAF) completed with DDRO authorization** (not required for *EMOD* referrals)
- **Behavior Support Plan (if applicable) for all sites that individual receives services** (not required for *Support Services* referrals)
- **Physical** (current within 1 year) **and list of all current medications** (not required for *Support Services* referrals)

****If you are requesting an EMOD, VMOD or ATECH, please continue to follow the existing OPWDD process for these services, however, the first four documents above will be required at the time of initial referral.**

Signature: _____ Date: _____
Title: _____

For Administrative Use Only

Required Document	**Date Received**		**Service Authorization**		
Referral Form			**Service**	**DDRO Authorized Units**	**Converted Units**
Life Plan/ISP					
Waiver NOD					
Current LCED					
FD Auth. Letter/SAF			☐ **Aspire has been identified as provider agency**		
BSP			☐ **Aspire has not been identified as provider agency**		
Physical/Medication List			☐ **This is a change of vendor from _____**		

Notes to staff for program review: