**Aspire of WNY Referral Form for OPWDD Waiver Services**

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): PCS  Prime Care

Phone #:**\_\_\_\_**-**\_\_\_\_**-**\_\_\_\_\_** CC Email: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

CC Mailing Address: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Services Requested: (Please check all that apply)**

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| --- | --- | --- |
| **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.**

**Is applicant enrolled in HCBS Waiver**:  Y  N  Pending- Date of submission to DDRO: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**For Day Habilitation requests only, date of graduation**: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Justification/Reason for referral:** (Required for all services- describe situation, use additional paper if needed) **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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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): **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

AmbulatoryNon-ambulatory  Explain any needed mobility supports:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Please list all medical diagnoses: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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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): **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**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 |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| 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? **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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Are there strategies/techniques that have been especially effective? Please describe. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Please describe any other important information or history regarding behaviors: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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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: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**List all current OPWDD and non-OPWDD** (Care Coordination, CASA, DOH, OMH, etc.) **services being received:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Service** | **Provider Name** | **Provider Contact Name** | **Provider Contact Phone #** |
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**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, Service Amendment Form (SAF) completed with DDRO authorization** (*not required for EMOD referrals*)**, or Authorization to Hire for Self Direction**
* **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** (*only required for all Day Services and Free-Standing Respite*)

**\*\*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 of Person Completing Referral:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_**

**Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| ***For Administrative Use Only*** |

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| --- | --- | --- | --- | --- | --- |
| **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**  **Aspire has not been identified as provider agency**  **This is a change of vendor from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |
| BSP |  |  |
| Physical/Medication List |  |  |

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| ***Notes to staff for program review:*** |