

Date of Application: _____

Name of Applicant: _____



Aspire of WNY Intake Application for OPWDD Waiver Services

Please complete this application in its entirety to avoid processing delays

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: _____

CC Supervisor Name: _____ Phone #: ____-____-_____

Supervisor Email: _____

Service(s) Requested: (Please check all that apply): *Please be aware that some services may be experiencing waiting periods due to COVID-19 or other factors. Please ask your Intake Specialist for more information*

<u>Site-Based Day Habilitation Programs:</u>	<u>Site-Based Respite Programs:</u>	<u>Self-Directed Services:</u>
<input type="checkbox"/> Day Habilitation (Includes 4 sites)	<input checked="" type="checkbox"/> Freestanding Respite	<input type="checkbox"/> Fiscal Intermediary and Support Broker
<input type="checkbox"/> Technology Today- Tonawanda Site	<input type="checkbox"/> After School Respite	<input type="checkbox"/> Fiscal Intermediary (only)
<u>Without Walls Programs (WOW):</u>	<input type="checkbox"/> Saturday Respite	<input type="checkbox"/> Support Broker (only)
<input type="checkbox"/> Supported Volunteering & Lifestyle Enrichment Program (SVLEP)	<u>In Home Respite:</u>	<input type="checkbox"/> Self-Hire Community Habilitation
<input type="checkbox"/> Aspire's CoOp Program	<input type="checkbox"/> Direct Provider Purchased	<input type="checkbox"/> Self-Hire Respite
<input type="checkbox"/> Technology Today- Buffalo	<input type="checkbox"/> Agency-Supported Self-Directed	
<u>Community Habilitation:</u>	<u>Vocational Services:</u>	<u>Support Services:</u>
<input type="checkbox"/> Direct Provider Purchased	<input type="checkbox"/> Community-Based Prevocational Service: Adult Development & Professional Training (ADAPT)	<input type="checkbox"/> Environmental Modification (E-MOD)
<input type="checkbox"/> Agency-Supported Self-Directed	<input type="checkbox"/> Pathways to Employment: Making Opportunities Via Vocational Experience (MOVE)	<input type="checkbox"/> Vehicle Modification (V-MOD)
<input type="checkbox"/> Residential (R)	<input type="checkbox"/> OPWDD Supported Employment/ETP	<input type="checkbox"/> Adaptive Technology

***To participate in Aspire's iXpress (North) art program, applicant will need to apply for CoOp and/or Tech Today- Buffalo**

***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.**

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Does applicant need a referral for Physical Therapy (PT), Speech Therapy (ST) or Mental Health Counseling (MH)?

Please check all that apply: None PT ST MH (If service(s) are checked, Care Coordinator will be provided the Article 16 intake packet to complete. This will then be provided to Aspire’s Health Care Center staff who will do all follow up, NOT Central Intake Staff. For all questions, please call Melinda Toomey 716.505.5634).

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

If yes, has Care Coordinator confirmed that Waiver status is ACTIVE? Y N

List all current OPWDD (i.e. Respite, Self-Direction, Day Hab, etc.) and non-OPWDD (Care Coordination, CASA, DOH, OMH, etc.) services being received:

Service	Provider Name	Provider Contact Name	Provider Contact Phone #

If the individual has Self-Direction, is plan established and budget active? Y N *If yes, please provide a copy of the FULL budget with your referral packet.*

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

Is this request a Change of Vendor Request: Y N If yes, previous agency: _____

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:

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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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bowels	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transfers while toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wash hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Undressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tub/Shower	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wash body	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wash hair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comb hair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brush teeth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Menstruation Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mealtime			
Eats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cuts food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cleans self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medication Administration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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 any current behavior plans, they will be required with this application.)

Are there any behavior concerns with this individual? Yes No if yes, please continue. If no, please skip to “*”.**

Does this individual have a behavior management program or plan at: Home School Day Program Other

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: _____

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**Is this individual sexually-consenting? Y N has not been evaluated unsure

Is this person under Psychiatric Care? Y N

If yes, name of provider(s): _____

Medications prescribed to treat behaviors: _____

Technology

1. Does individual requesting services have internet access in their home?

Yes No Comment: _____

2. Does individual requesting services have access to a smart device? Yes No

• Computer? Yes No Comment: _____

• Tablet? Yes No Comment: _____

• Smart phone? Yes No Comment: _____

3. Does individual requesting services have unlimited data or access to a data plan?

Yes No Comment: _____

4. Can individual requesting services independently use their technology? Yes No

If you answered No to question 4, why not, please explain what support is needed. _____

The following list of documents must be provided to Aspire’s Central Intake Department before referral packet can be transferred for programmatic review:

We strongly encourage entire referral packet be sent together for tracking purposes. Referrals will not be processed nor will individuals be placed on waiting lists until complete packet is received

- **Aspire of WNY Intake Application for OPWDD Waiver Services**
- **Most Recent Life Plan**
- **HCBS Waiver Notice of Decision (NOD) OR Tabs Inquiry** from CHOICES if NOD is not available
- **Current Level of Care Eligibility Determination (LCED)**
- **Front Door Authorization Letter** (entire letter)/Entire **Service Amendment Form (SAF)** completed by the Care Coordinator, with DDRO authorization OR **Authorization to Hire** for Self-Direction (*not required for EMOD/VMOD referrals*)
- **Behavior Support Plan(s)** (if applicable) for all sites that individual receives services (*not required for EMOD referrals*)
- **Physical (current within 1 year) and list of all current medications** (*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.**

Person Completing Referral (*typed or hand-written*): _____

Title of Person Completing Referral: _____

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For Administrative Use Only

Required Document	Date Received	Service Authorization		
		Service	DDRO Authorized Units	Converted Units
Referral Form				
Life Plan				
Waiver NOD/Tabs Inquiry				
Current LCED				
FD Auth. Letter/SAF		<input type="checkbox"/> Aspire has been identified as provider agency		
BSP		<input type="checkbox"/> Aspire has not been identified as provider agency		
Physical/Medication List		<input type="checkbox"/> This is a change of vendor from _____		

Notes to staff for program review: