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*

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

_____

Date of Application: Name of Applicant: _____

**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: _____

Date:

Date of Application: Name of Applicant: _____

For Administrative Use Only

Required Document	Date Received		Service Authorization		
Referral Form			**Service**	**DDRO Authorized Units**	**Converted Units**
Life Plan					
Waiver NOD/Tabs Inquiry					
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: