

### Dear Applicant:

Thank you for your interest in CDS Monarch. Please complete the enclosed application. In addition to the completed application, we will need the following information:

## Eligibility Documents

OPWDD Eligibility Letter
HCBS Waiver Enrollment (NOD)
Level of Care Determination (Current)Service
Authorization Letter / Approved SARF

## Supporting Documents

Life Plan (Most recent)
Current IPOP
Current IEP
Behavior Support Plan (+ 1yr of data collection)
Vocational Assessments
ACCESS Case Closure Letter
Social Work Evaluation (If available)
Current DDP2 (with ISPM Score)
Psychological Evaluation (Most Recent)

## Medical Documents

Current Physical (within last year)
Current Medication List/Allergies
Diet Orders/Dining Conditions
2-Step PPD/TB Test Results (2 tests, within 1yr)
Signed Doctor's Orders
Any Documented Medical Restrictions
Any Recent Clinical Evaluations



#### Other Documents

Legal Guardianship Documents (If Applicable)
Photo ID (Employment Applicants Only)
Copy of Birth Certificate (Residential Applicants Only)
Copies of Insurance Cards (Residential Applicants Only)
Copy of Social Security Card (Residential Applicants Only)
SSI/SSD/SSA Award Letters ((Residential Applicants Only)
Bank Account Statements (Residential Applicants Only)

The Intake Committee will accept the most recent assessments available for the purposes of intake only. However, the agency requires more current assessments before placement in any CDS Monarch program.

Once you have gathered this information, please submit to:

Kristin Hart, Residential Intake Manager
CDS Monarch
860 Hard Rd.
Webster, NY 14580
Kristin.Hart@CDSMonarch.org

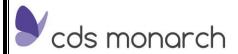
Once received, we will review the application and contact you. An efficient intake process is the goal of CDS and we look forward to providing you with quality services. If you have any questions, please contact me at (585) 314-0466 or via email at kristin.hart@cdsmonarch.org. Again, thank you for your interest in our agency.

#### Mission

CDS Monarch is an organization of highly-skilled, dedicated people that that offers quality opportunities and services to individuals for their well being and growth.

#### Vision

CDS Monarch is a world-class organization that supports people in pursuit of their personal dreams.



Date of Application:
Date Service Needed:
Date Application Received

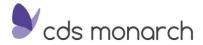
Individual's Name:

## <u>SUPPORTS REQUESTED</u> (Check all that apply):

Residential (i.e. family Care, ISS Contracts, IRA's, Community Living)
Employment Services
Site-Based Prevocational Services
Community-Based Prevocational Services
Recreation/Respite (age 5 – adult)
Parent Support Group
Autism Skill Building Program (6-16)
Community Habilitation
Site-Based Day Habilitation
Day Habilitation Without Walls

(NYCARES) New York State Cares Enrolled: Yes No Waiver Enrolled: Yes No **Care Manager / Coordinator:** Phone #: Address: Fax #: Email: School District (if applicable): Phone #: **Contact Name:** Email: Fax #: Have you ever received CDS Monarch services in the past? No How did the individual/family learn about CDS Monarch? (Please Specify) Family or Friend Meeting or Event Agency CDS Monarch Employee Other Social Media/TV/Radio URGENCY OF NEED: ☐ Immediate ☐ Within 1 year After 1 year Completed by: Phone #: Email:

Individual's Name:			Sex: Male Fer	nale			
Address <sub>:</sub>			Type of Residence	ce:			
D.			Birth date:				
Phone:			Medicaid #:				
Social Security #:			Tabs ID #				
Self-Advocacy	Self-Advocates Independ Self-Advocates with Assi Requires Supervision Ad	stance					
Benefits:	SSI	SSD	Public Assistance	ce Food S	Stamps #		
	Life Insurance	Trust Fund	Burial Fund				
	Medicare #:	: Medicare Part D Carrier:					
	Spend Down (please describe):						
	Pay Back (please describe)	ay Back (please describe):					
	Representative Payee:						
Disabilities:	Intellectual/Developmental Disability		Learning Disability		Cerebral Palsy		
	Autism	Neurological I	mpairment	Epilepsy (type):			
	Other (specify):						
Medication (list and dosage):							
GUARDIANSHIP / (	CORRESPONDENTS:						
Legal Guardian:			Date Established:		Not Established		
Family/Advocate Contact:			Relationship:				
Address:			Phone:				
			Email:				
Alternate Contact:		Relationship:					
Address:			Phone:				
Day Program:			Email: Contact:				
Address:			Phone:				



## **SERVICES CURRENTLY RECEIVING** (Check all that apply)

RESIDENTIAL CASE MANAGEMENT FAMILY SUPPORT

Community Residence Care Coordination Autism Family Support

ICF TBI (Traumatic Brain Injury) HCBS Waiver

IRA (Group Home) PCSS (Plan of Care Support Services) Parent Support Group

Supervised Apartment Residential Habilitation (Community)
Supportive Apartment Recreation (Ages 5 to Adult)

Family Care Other:

DAY SERVICES CLINICAL SERVICES

Day TreatmentIndividual PlacementSocial WorkCounselingDay HabilitationSupported EnclavesOccupational TherapySpeech TherapySheltered WorkshopSchoolPhysical TherapyNursing Services

Prevoc. Services Transition Program Services Psychiatry/Psychology

Other:

**LEVEL OF SUPERVISION NEEDED:** (Please indicate whether the Individual needs: total support, assistance, supervision or is

independent for the following skills)

Food Prep: House Keeping: Toileting: Fire Evacuation:

Cooking: Laundry: Dressing: Community Safety Skills:

Eating: Phone Usage: Grooming:

Shopping: Bathing: Money Management:

**TRANSPORTATION:** (Check all that apply)

Able to Use Lift Line Has Drivers License (No Car)
Has Own Car Needs Transportation
Able to Use RTS Can Take a Taxi
Potential for Travel Training School Bus with aide

**MOBILITY STATUS:** (Check all that apply)

Ambulatory

Uses manual wheelchair

Requires use of lift

One-person transfer

One-person transfer

Can be transported in a car

Able to negotiate stairs

Several person transfer

Requires vehicle with lift\*

\*Buses are equipped with a Braun Lift. Maximum wheelchair size is 34" wide X 54" length. The weight capacity of the lift is 800 lbs. or 1,000 lbs. depending on the model of the lift installed in the vehicle. The weight capacity includes the total weight of the individual + the weight of the wheelchair. If you have questions or concerns about transportation please contact (585) 347-1601 and we will be happy to assist.

**COMMUNICATION:** 

Primary Language: Requires an Interpreter Yes No Verbal Yes No Uses sign language Yes No

BEHAVIOR SUPPORT PLAN OR GUIDELINES: Yes (If yes, please attach behavior support plan & data collection for

past year) No

Even if no, please describe any behaviors, safe guards or special needs:



I,the Intake Committee.	_hereby authorize the release of information to 0	CDS Monarch and
The purpose of this disclosure is referral for CDS services. I below and that CDS/Intake Committee and all of the participa CDS, the Intake Committee, and all participating agencies will	iting agencies will maintain the confidentiality of t	
Information to be Released	Date of Document	<u>Attached</u>
OPWDD Eligibility Letter HCBS Waiver Enrollment (NOD) Level of Care Determination (Current) Service Authorization Letter / Approved SARF Life Plan (Most recent) Current IPOP Current IEP Behavior Support Plan (+ 1yr of data collection) Vocational Assessments ACCESS Case Closure Letter Social Work Evaluation (If available) Current DDP2 (with ISPM Score) Psychological Evaluation (Most Recent) Current Physical (within last year) Current Medication List/Allergies Diet Orders/Dining Conditions 2-Step PPD/TB Test Results (2 tests, within 1yr) Signed Doctor's Orders Any Documented Medical Restrictions Any Recent Clinical Evaluations Legal Guardianship Documents (If Applicable) Photo ID (Employment Applicants Only) Copy of Birth Certificate (Residential Applicants Only Copies of Insurance Cards (Residential Applicants SSI/SSD/SSA Award Letters ((Residential Applicants SSI/SSD/SSA Award Letters ((Residential Applicants Only Bank Account Statements (Residential Applicants Only Copies of Insurance Cards (Residential Applicants SSI/SSD/SSA Award Letters ((Residential Applicants Only Bank Account Statements (Residential Applicants Only Copies of Insurance Cards (Residential Applicants SSI/SSD/SSA Award Letters ((Residential Applicants Only Bank Account Statements (Residential Applicants Only Copies of Insurance Cards (Residential Applicants SSI/SSD/SSA Award Letters ((Residential Applicants Only Card (Residential Applicants	Only) s Only) s Only)	
Applicant's Signature	Advocate/Legal Guardian Signature	<u> </u>
Date	Date	_
	Relationship to Applicant	

NOTE: THIS CONSENT MAY BE REVOKED AT ANY TIME BY PUTTING SUCH REQUEST IN WRITING AND SUBMITTING TO THE INTAKE MANAGER.

Kristin Hart, Residential Intake Manager

860 Hard Rd.Webster, New York 14580 Phone: (585) 314-0466

kristin.hart@cdsmonarch.org



Name / Title

# **Interests Inventory**

Individual Name:	Date:	Date:			
Indicate which interests are maintained by the person. V	When known, please provide any additional details (Example: Animals: Dogs,	Horses, etc)			
Animals:	Music:				
Art:	Outdoors:				
Being-Alone:	People:				
Books:	Photographs:				
Bowling:	Photography:				
Carnivals:	Praise:				
Cars:	Recognition:				
Celebrations:	Responsibilities:				
Challenges:	Restaurants:				
Children:	Rides:				
Church:	Sewing:				
Cleaning:	Shopping:				
Collecting-Things:	Singing:				
Community -Outings:	Skating:				
Computers:	Sleeping:				
Concerts:	Smoking:				
Cooking:	Socializing:				
Crafts:	Sports:				
Crowds:	Swimming:				
Dancing:	Talking:				
Doctors:	Television:				
Drawing:	Theatre:				
Electronics:	Traveling:				
Fishing:	Vacations:				
Foods:					
Games:	Variety: Visiting-Others:				
Gardening:	Volunteering:				
Helping -Others:	Walking:				
Housework:	Work:				
	Writing:				
Magazines:	Yardwork:				
Money: Movies:	Other:				
	other.				
Museums:					
0 11 11					
Completed by:					
Name / Title					