



The Arc Westchester

NEW PARTICIPANT APPLICATION

Recreation / Respite / Community Habilitation Services

Thank you for your interest in The Arc Westchester’s Recreation, Respite, or Community Habilitation services! Individuals applying to The Arc Westchester for these services must be eligible for OPWDD services (Office for People with Developmental Disabilities) and have OPWDD authorization for the requested service(s).

INSTRUCTIONS: All individuals, in conjunction with their parent(s)/guardian(s), or Care Manager, are to complete this packet to be considered for participation in The Arc Westchester Recreation, Respite, or Community Habilitation services. In addition to this application, specific documentation is required. The documents listed below must be sent together with this application for consideration in service(s).

Required Documentation:

- IEP (if currently attending high school or exited/graduated within the past 2-years)
- Current Life Plan
- Psychological Evaluation
- Copy of Medicaid Card (front and back)
- The Arc Westchester’s New Participant Medical Form
- Copy of Immunization Records
- Copy of ParaTransit card (*if applicable*)
- Guardianship Documentation (*if applicable*)
- *OPWDD Service Authorization Letter (**only required upon acceptance*)
- *Self-Direction Budget (*if applicable, *only required upon acceptance*)
- *Life Plan Addendum listing The Arc Westchester (*if applicable, *only required upon acceptance*)

Please fully complete the entire application with the supporting documentation, and return it to:

(THIS SECTION IS TO BE COMPLETED BY THE ARC WESTCHESTER)

By Email: _____

- OR -

By USPS: The Arc Westchester
Attn: _____
265 Saw Mill River Road.
Hawthorne, NY. 10532

Enrollment into a service will not proceed until all materials are received and reviewed, an intake interview is completed, and the necessary OPWDD and The Arc Westchester approvals are also completed.

If you need assistance compiling this information, please contact your Care Manager.

For questions regarding this application please contact: _____

DESIRED SERVICES (CHECK ALL THAT APPLY):

Community Habilitation

- Recreation & Respite Department:** Daycation/Day Trips Weekend Overnight Trips
 Gateway Program (The Arc Westchester's Choices only) Prep4Success
 Free Standing Respite House (Thornwood, NY) Echo on Stage @WCC (Summer) Arc Theater
 Summer Enrichment @ Manhattanville Summer Weeklong Trips
 Site-Based Day Hab **Without Walls (WOW) Day Hab**

APPLICANT DEMOGRAPHIC INFORMATION:

First Name: Middle I: Last Name: Nickname:

Date of Birth: Age: Sex: Social Security #:

Street Address (Primary Residence) City: State, Zip Code:

Mailing Address (if different from above): _____

Cell Phone Number: _____ N/A, does not have a cellphone

Medicaid Number: _____ Medicare # (if applicable): _____

Medical Insurance Company: _____ Policy #: _____

**Attach copies of Medicaid/ Medicare or Insurance card (both front and back) **

Religion: Baptist Buddhist Catholic Christian Hindu Jehovah’s Witness Jewish Lutheran
Methodist Mormon Muslim Pentecostal Prefer not to say Unknown Wicca Other: _____

Ethnicity: Black Hispanic Native American Pacific Islander or Asian White Other: _____

PARENT/LEGAL GUARDIAN* CONTACT INFORMATION:

***Attach copy of decree (adults with guardianship only)**

Parents: Married Separated Divorced Other: _____

1. _____
Last Name: First Name: Relationship to Applicant:

Home Phone: Cell Phone: Email Address:

Street Address (if different from applicant): City: State, Zip Code:

CONT. PARENT/LEGAL GUARDIAN* CONTACT INFORMATION:

2.

Last Name:

First Name:

Relationship to Applicant:

Home Phone:

Cell Phone:

Email Address:

Street Address (if different from applicant):

City:

State, Zip Code:

In Case of Emergency (other than parent/guardian):

In the event of an emergency, should The Arc Westchester be unable to reach the parent(s)/guardian(s) listed above, please provide contact information for two additional people to contact in case of an emergency.

1.

First Name:

Last Name:

Relationship to Applicant:

Primary Phone:

Additional Phone:

2.

First Name:

Last Name:

Relationship to Applicant:

Primary Phone:

Additional Phone:

SCHOOL & PROVIDER CONTACT INFORMATION:

Name of High School (attending or attended)

Town/District:

Exit Year:

School Contact: _____

Please list any other agencies or services received (including Day Hab, Comm Hab, Respite services, etc.)

Service:	Agency:	Contact Person, Phone & Email:
1.		
2.		
3.		
4.		
5.		

ParaTransit #: _____

N/A, does not have ParaTransit

CARE MANAGER CONTACT INFORMATION:

Care Manager (CM) Name: _____

CCO (LIFEPlan, Care Design, Advanced Care Alliance, Tri-County, PHP): _____

Email Address: _____

Phone: _____

Additional Phone: _____

Does the applicant have Self-Direction? NO Approval Pending YES, if yes or pending:

Broker Name: _____ Email: _____ Phone: _____

FI Name: _____ Contact Information: _____

DAILY LIVING SKILLS

We would like to know about the applicants current Level of independence in performing activities of daily living. For each activity, please check the column which best describes the applicant’s ability to do the task. For example, Independent would mean applicant is able to do the task without any help, verbal reminders, or assistance.

ACTIVITY:	INDEPENDENT, No Assistance or Prompting	*SOME Assistance / Prompting Needed	COMPLETE Assistance (or done for them)	*IF SOME ASSISTANCE IS NEEDED, DESCRIBE:
Bathing / Showering:				
Dressing / Undressing:				
Grooming, brushing teeth, combing / brushing hair				
Washes hands thoroughly after use of bathroom				
Maintains a regular sleep schedule				
Uses alarm or other technology for reminder systems				
Toileting, Maintains Continence:				
Walking:				
Transferring, Mobility, Climbing Stairs:				
Prepares Simple Foods (e.g., sandwiches, cold cereal, etc.):				
Manages Medications (takes correct medication at the correct time)				

ACTIVITY:	INDEPENDENT, No Assistance or Prompting	*SOME Assistance / Prompting Needed	COMPLETE Assistance (or done for them)	*IF SOME ASSISTANCE IS NEEDED, DESCRIBE:
Send text messages & make phone calls				
Carries cash, credit, or debit card and makes small purchases				
Coordinates Transportation				
Wears Mask or Face covering in accordance with current OPWDD or CDC mandates				

COMMUNICATION:

Applicant's primary language: English Sign Language Spanish Other: _____

Describe the applicant's communication skills:

	Excellent	Good	Fair	Poor	
Receptive:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Expressive:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> the applicant is non-verbal

Does the applicant have an alternate form of communicating (e.g., picture board, Proloquo, or other communication apps): Yes No If yes, describe: _____

BEHAVIOR & SUPERVISION:

Does the applicant currently receive therapeutic services including, but not limited to, Speech therapy, Occupational therapy, Physical therapy, behavioral or talk therapy?

Yes** **No**

Does the applicant have behavioral issues that may require specialized supports (behaviors such as: physical aggression, verbal outbursts, self-injurious, property destruction, impulsivity, sexual or other behavior)?

Yes** **No**

Have there been any episodes of aggressive, disruptive, or injurious behaviors in the past 12-months?

Yes** **No**

****If Yes**** to any of the questions above please provide a detailed description of the behaviors, frequency, and support needs:

Does the applicant currently, or have they had within the past 12-months, a behavior support plan? Yes No
If yes, submit a copy of the plan along with this application

Does the applicant have a history of elopement behavior (leaving a designated area without permission either by bolting, running, or wandering). Yes No

If yes, describe: _____

Describe the applicant's ability to interact socially with peers:

Has the applicant ever slept away from home? Yes No

Indicate how long the applicant can be left home alone at a time.

Never less than 30-minutes 30-60 minutes 1-2 hours 3-hours or more

Indicate how much time the applicant spends alone in a familiar community setting (e.g., Starbucks, library, walk around the neighborhood, local store, etc.):

Never less than 30-minutes 30-60 minutes 1-2 hours 3-hours or more

Additional Information:

APPLICATION COMPLETED & RETURNED BY:

PLEASE PRINT Name & Relationship to Applicant: Signature: Date:

CONTACT INFO:

Phone: Email:

Thank you!

We appreciate your interest and for applying to The Arc Westchester for services! This application enables the Review Committee to assess the applicant's skills, abilities, and background properly. The Review Committee may contact a parent, guardian, or Care Manager to gather additional information. Once the application packet has been reviewed, we will contact you to discuss the next steps.

Please note: Applications will be reviewed for consideration once all required materials (as listed on page one) are received. If you need assistance compiling this information, please contact your Care Manager.