Return to
CP Rochester
3399 Winton Road South
Rochester, NY 14623
585-334-6000 ext. 2281

Intake Application

Please complete all sections of this application and do not leave any blanks. *Please print.*

Application is being made to the following program: (check one)

❑ Day Habilitation
❑ Community Habilitation
❑ Free Standing Respite
❑ Hourly Respite (*Please circle one*: In Home, Wrap Around or Recreation)
❑ Residential
❑ Care at Home Service Coordination

1. Individual Information:

Individual's Full Name: ______________________________
Date of Birth: ____________________
Gender: ❑ Male ❑ Female
Social Security Number: ___________________
Current Address: ____
Street City State Zip
Phone number: (____) _____________ Email: _____________________________
Medicaid Number: _____________________
Medicare: ___________________________
Other Insurance (Name/number etc.):______________________________________
Current Residence ❑ Family Home ❑ Independent ❑ Certified Agency_____________________

2. Describe the reason(s) the individual is requesting services from CP Rochester.
(Please attach separate sheet if necessary. Please do not state "refer to…" another document.)

____
____
____

3. In case of emergency, the following person(s) are to be called: *Submit guardianship papers as appropriate*

Contact 1: Name____

Relationship: ❑ Parent ❑ Court Appointed Guardian ❑ Other______________________
Current Address: ____
Street City State Zip
Home Phone: (____) _____________ Alternate/Work Phone: (____) _____________

Contact 2: Name____

Relationship: ❑ Parent ❑ Court Appointed Guardian ❑ Other______________________
Current Address: ____
Street City State Zip
Home Phone: (____) _____________ Alternate/Work Phone: (____) _____________

4. Service Coordinator Name: ____

Agency: ____

Address: ____

Street City State Zip

Phone Number: (____) ________________ Fax: ____________________________

Email: ____________________________________ Emergency on Call#:_______________

5. Self-Directed Broker (*If Applicable*) **Name:** ______________________________________

Agency: ____

Phone Number: (____) ________________ Email: ____________________________________

6. School/Program Information:

Is the individual attending: ❑ School ❑ Day Program ❑ SEMP ❑ Other______________________________

School or Program Name: ____

School/Program Address: ____

Street City State Zip

Contact Name: ____

Contact Phone Number: (____) ________________

Transportation Provider: ____

Transportation Contact Name: ____

Contact Phone Number: (____) ________________

Primary Language (communication skill):

- ❑ English
- ❑ Spanish
- ❑ American Sign Language
- ❑ Non-verbal
- ❑ Symbolic (type____________________)
- ❑ Communication device (type_____________________)
- ❑ Other __________________________

Comprehension Ability:

- ❑ comprehends verbal directions without problems
- ❑ understands simple directions
- ❑ does not understand simple directions
- ❑ Understands Sign Language
- ❑ other, please describe: __________________
  ____
  ____

7. Primary Health Care Provider:

Primary Physician: ____

Address: ____

Street City State Zip

Phone Number: (____) ____________ Fax: _______________ Email: __________________________

Hospital Affiliation: ________________________________ Emergency on Call: ____________________

Primary Diagnosis: ____________________________________

Secondary Diagnosis: __________________________________

8. **Medical Info:**

- Does the individual have any known **allergies**? (i.e., foods, medications, environmental) ❑ Yes ❑ No
  If yes, please indicate reaction:

____

____

____

- Does the individual utilize an epi pen? ❑ Yes ❑ No

- Does the individual have a **seizure disorder**? ❑ Yes ❑ No *If yes, please describe a typical seizure episode as fully as possible, including physical characteristics, duration, and any warning signs that a seizure is about to occur.*

____

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____

____

- Date of last seizure: ________________How often do seizures occur? ________________________________

- Is the individual capable of **self-medication** administration? ❑ Yes ❑ No

If yes, please describe any special needs and supports needed by the individual for self-medication administration.

____

____

- Does the individual have any special needs to enable them to take medication? (i.e., taking the medication in pudding, with a certain cup, in a special way) ❑ Yes ❑ No *If Yes, please describe those special needs.*

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____

- Does this individual have any medical health issues that have not been covered in this application?

____

____

Medication Regimen: *Please list all current medications*.

Medication	Dose	Frequency	Why is Medication Taken

9. **Does the individual demonstrate any of the behaviors below?** *(Please note, if the individual is exhibiting age appropriate behaviors (for young children) you do not need to it describe here.)*

Please Include Frequency

BEHAVIOR	YES/NO	DAILY	WEEKLY	MONTHLY
Physically assaults others				
Wandering/Running Away				
Destroys Property				
Tantrums/Emotional Outbursts				
Self-Injurious Behavior				
Verbally/Gesturally Aggressive				
Mouthing/Swallowing or eating non-food items				
Interactions with others that are not appropriate (Disrupts others, teases, harasses peers)				
Resists Supervision				
Displays Sexually Inappropriate Behavior				
Steals				
Other Challenging Behaviors				

Does the individual have a current written behavioral support plan or guidelines? ❑ Yes ❑ No
If yes, please complete the following and attach current plan:

- **If there is a plan, where is it implemented?**
- **Has the plan been effective?**
- **Are there things that are more likely to cause the behavior to happen?** *(please explain)*
- **If there is no plan in place, how do you assist the individual with challenging behavior?**
- **Is there anything else you would like us to know about this individual's behavior that is important?**

Has the individual ever been convicted of a felony or misdemeanor or have a High Risk Plan?
❑ Yes ❑ No *If yes, please list dates and offense:* ____

____

____

____

10. Social and Recreational Activities

a. Describe how the individual interacts with peers, younger children and authority figures.

b. Are there any special concerns when the individual is in the community (on an outing for example)? What supervision or supports are needed to participate in these activities? (Please include pedestrian skills, ability to interact safely with strangers)

c. Please list the individual's preferred activities/interests.

Please attach the following documents:

- Current ISP or IEP with pertinent documentation (IPOPs, dietary guidelines, transfer guidelines etc.)
- Current Psychological Assessment
- Current Physical Exam
- Current Social Assessment
- Behavior Support Plan with 1 year of data
- Completed HIPAA forms
- Notice of Decision or Documentation of Disability
- RSA (Request for Service Authorization)
- Copy of DDP2
- Initial and Current Level of Care
- Current PPD (site based services only)

Thank you for completing this form.

Print Name of person completing this form ______________________________

Relationship to Individual ____

Signature of person completing form __________________________________ Date __________

For Office Use Only

Date Received ________________

Has Individual/Family attended Front Door Session? ❑ Yes ❑ No

Scores

ISPM ____________ Adaptive ____________ Behavior ____________ Health ____________