Return to
CP Rochester Intake
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
- ❑ Hourly Respite (*Please circle one*: In Home, Wrap Around or Recreation)
- ❑ Residential
- ❑ Free Standing Respite

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.*

_____
_____
_____
_____

- 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.*

_____
_____

- 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 Life Plan 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
- SARF (Service Authorization Request Form)
- 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 _____