



Dear Applicant:

Thank you for your interest in CDS Monarch. Enclosed is a packet of information about our agency and an application for services.

Please complete the enclosed application. In addition to the completed application, we will need the following information:

- 📎 OPWDD Eligibility Letter
- 📎 Waiver Enrollment (NOD)
- 📎 Current DDP2 with ISPM Score
- 📎 Level of Care Determination
- 📎 Legal Guardianship Papers (if available)
- 📎 Psychological Eval (most recent)
- 📎 Social Work Eval (if available)
- 📎 Life Plan (most recent)
- 📎 IPOP (if applicable)
- 📎 IEP (if applicable)
- 📎 Vocational Assessments (if applicable) Work Restrictions (if applicable)
- 📎 Photo ID
- 📎 Behavior Support Plan (1 year data collection, if available)
- 📎 Current Physical (**within last year**) Current Medication List/Allergies
- 📎 Diet Orders/Dining Conditions
- 📎 2-Step PPD/TB Test Results (**2 tests, within 365 days of one another**)
- 📎 Signed Doctor's Orders (requirement can be waived if current physical is signed by MD)
- 📎 Preliminary Person Centered Plan, Interests Inventory, Signed Release of Information FLDDSO
- 📎 Community Hab Authorization Form (Comm. Hab only)
- 📎 Sexuality Assessment (if available)

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 fax to 585-347-1234 or mail/email to:

Pete Wills, Program Intake Coordinator
Or
Kris Hart, Residential Intake Coordinator
CDS Monarch
860 Hard Rd.
Webster, NY 14580

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) 507-0535 or via email at Peter.Wills@cdsmonarch.org. Again, thank you for your interest in our agency.

Mission

CDS Monarch is an organization of highly-skilled, dedicated people 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: _____

SUPPORTS REQUESTED (Check all that apply):

- Housing (i.e. family Care, ISS Contracts, IRA's, Community Living)
- Employment
- Care Coordination
- Recreation/Respite (age 5 – adult)
- Parent Support Group
- Autism Skill Building Program (6-16)
- Community Prevocation Services
- Community Habilitation
- Day Habilitation
- Senior Living

Waiver Enrolled: Yes No NOD date: _____

(NYCARES) New York State Cares Enrolled: Yes No

Care Coordinator: _____

Agency: _____ Phone #: _____

Address: _____

Email: _____ Fax #: _____

School District (if applicable): _____

Contact Name: _____ Phone #: _____

Email: _____ Fax #: _____

Have you ever received CDS Monarch services in the past? Yes No

How did the individual/family find out about CDS Monarch? Self Family Friend Website
 Agency _____
 Other: _____

URGENCY OF NEED: Immediate Within 1 year After 1 year

Completed by: _____ Phone #: _____ Email: _____

Individual's Name: _____

Sex: Male Female

Address: _____

Type of Residence: _____

Phone: _____

Birth date: _____

Social Security #: _____

Medicaid #: _____

Tab ID # _____

- Benefits:**
- SSI SSD Public Assistance Food Stamps # _____
 - Life Insurance Trust Fund Burial Fund
 - Medicare #: _____ Medicare Part D Carrier: _____
 - Spend Down (please describe): _____
 - Pay Back (please describe): _____
 - Representative Payee: _____

- Disabilities:**
- Intellectual/Developmental Disability Learning Disability Cerebral Palsy
 - Autism Neurological Impairment 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:** _____

_____ **Email:** _____

Day Program: _____ **Contact:** _____

Address: _____ **Phone:** _____



SERVICES CURRENTLY RECEIVING (Check all that apply)

RESIDENTIAL

- Community Residence
- ICF
- IRA (Group Home)
- Supervised Apartment
- Supportive Apartment
- Family Care

CASE MANAGEMENT

- Care Coordination
- TBI (Traumatic Brain Injury)
- PCSS (Plan of Care Support Services)

FAMILY SUPPORT

- Autism Family Support
- HCBS Waiver
- Parent Support Group
- Residential Habilitation (Community)
- Recreation (Ages 5 to Adult)
- Other: _____

DAY SERVICES

- Day Treatment
- Day Habilitation
- Sheltered Workshop
- Prevoc. Services
- Other _____

- Individual Placement
- Supported Enclaves
- School
- Transition Program Services

CLINICAL SERVICES

- Social Work
- Occupational Therapy
- Physical Therapy
- Psychiatry/Psychology
- Counseling
- Speech Therapy
- Nursing Services

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: | Money Management: | Bathing: | |

TRANSPORTATION: (Check all that apply)

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

MOBILITY STATUS: (Check all that apply)

- Ambulatory
- Requires use of lift
- Able to bear weight
- Uses manual wheelchair
- 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.

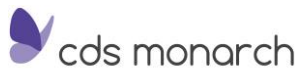
COMMUNICATION:

- Primary Language: _____
- Verbal Yes No
- Requires an Interpreter 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: _____



CONSENT FOR RELEASE OF INFORMATION

I, _____ hereby authorize the release of information to CDS Monarch and the Intake Committee.

The purpose of this disclosure is referral for CDS services. I understand that this authorization covers only the information listed below and that CDS/Intake Committee and all of the participating agencies will maintain the confidentiality of this information. CDS, the Intake Committee, and all participating agencies will not release this information.

Information to be released: (Please attach all documents)	Date of Form/Assessment	Attached
<input type="checkbox"/> OPWDD Eligibility Letter		<input type="checkbox"/>
<input type="checkbox"/> Waiver Enrollment (NOD)		<input type="checkbox"/>
<input type="checkbox"/> Current DDP2 with ISPM Score		<input type="checkbox"/>
<input type="checkbox"/> Level of Care Determination		<input type="checkbox"/>
<input type="checkbox"/> Legal Guardianship Papers (if available)		<input type="checkbox"/>
<input type="checkbox"/> Psychological Eval (most recent)		<input type="checkbox"/>
<input type="checkbox"/> Social Work Eval (if available)		<input type="checkbox"/>
<input type="checkbox"/> ISP (most recent)		<input type="checkbox"/>
<input type="checkbox"/> IPOP (if applicable)		<input type="checkbox"/>
<input type="checkbox"/> IEP (if applicable)		<input type="checkbox"/>
<input type="checkbox"/> Vocational Assessments (if applicable)		<input type="checkbox"/>
<input type="checkbox"/> Work Restrictions (if applicable)		<input type="checkbox"/>
<input type="checkbox"/> Photo ID		<input type="checkbox"/>
<input type="checkbox"/> Behavior Support Plan (1 year data collection, if available)		<input type="checkbox"/>
<input type="checkbox"/> Current Physical (within last year)		<input type="checkbox"/>
<input type="checkbox"/> Current Medication List/Allergies		<input type="checkbox"/>
<input type="checkbox"/> Diet Orders/Dining Conditions		<input type="checkbox"/>
<input type="checkbox"/> PPD/TB Test (2 step, within 365 days of one another)		<input type="checkbox"/>
<input type="checkbox"/> Signed Doctor's Orders (requirement can be waived if current physical is signed by MD)		<input type="checkbox"/>
<input type="checkbox"/> FLDDSO Community Hab Authorization Form (Comm. Hab only)		<input type="checkbox"/>

Applicant's Signature

Advocate/Legal Guardian Signature

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 / GUARDIANSHIP COORDINATOR.

Francesca Triest, Intake and Guardianship Coordinator

860 Hard Rd.

Webster, New York 14580

Phone: (585) 347-1227 Fax: (585) 347-1234

Francesca.Triest@cdsmonarch.org

Preliminary Person Centered Plan

Name: _____

Advocate (if Appropriate): _____

Self-Advocacy

- Self-Advocates Independently
- Self-Advocates with Supervision or Assistance
- Requires Total Assistance with Advocating

Information Regarding Applicant: Diagnosis, Functioning Ability, etc.;

Current Services

What current services are working for you?

What services are *not* working for you?

Are there any health and/or safety concerns that need to be addressed?

What services have been explored and have not met the individual's needs?

Person completing this form: _____

Relationship and Contact Information: _____

Person Centered Planning
To be completed by Individual and/or Advocate.

How would you describe _____?
Name

Who is in _____'s circle of support? (non-paid, natural supports)
Name

What must _____ have to be happy?
Name

What has helped _____ to grow and develop?
Name

What are _____'s personal obstacles?
Name

Interests Inventory

Individual Name: _____ Date: _____

Indicate which interests are maintained by the person. When known, please provide any additional details (Example: Animals = Dogs, Horses, etc)

- Animals: _____
- Art: _____
- Being Alone: _____
- Books: _____
- Bowling: _____
- Carnivals: _____
- Cars: _____
- Celebrations: _____
- Challenges: _____
- Children: _____
- Church: _____
- Cleaning: _____
- Collecting Things: _____
- Community Outings: _____
- Computers: _____
- Concerts: _____
- Cooking: _____
- Crafts: _____
- Crowds: _____
- Dancing: _____
- Doctors: _____
- Drawing: _____

- Electronics: _____
- Fishing: _____
- Foods: _____
- Games: _____
- Gardening: _____
- Helping Others: _____
- Housework: _____
- Magazines: _____
- Money: _____
- Movies: _____
- Museums: _____
- Music: _____
- Outside (being): _____
- People: _____
- Photographs: _____
- Photography: _____
- Praise: _____
- Recognition: _____
- Responsibilities: _____
- Restaurants: _____
- Rides: _____
- Sewing: _____
- Shopping: _____
- Singing: _____
- Skating: _____
- Sleeping: _____
- Smoking: _____
- Socializing: _____

- Sports: _____
- Swimming: _____
- Talking: _____
- Television: _____
- Theatre: _____
- Traveling: _____
- Vacations: _____
- Variety: _____
- Visiting Others: _____
- Volunteering: _____
- Walking: _____
- Work: _____
- Writing: _____
- Yard work: _____
- Zoo: _____

Other Activities Not Listed: _____

Completed by: _____
Name / Title

Name / Title

How did you hear about us? (Check all that apply)

Family Member of Friend

Care Coordinator

CDS Monarch Employee

Community Event (please specify) _____

Job Search Site (i.e. Careerbuilder, Indeed)

Search Engine (i.e. Google, Bing, Yahoo)

Social Media

Radio

Other: (please specify) _____