NOR-WEST REGIONAL SPECIAL SERVICES

Participant Application

Mailing Address:
P. O. Box 44
Mohegan Lake, NY 10547
Fax: (914) 737-4838

www.nor-west.org

Office Location:
3131 East Main Stret
Mohegan Lake, NY 10547
(914) 737-4797

INSTRUCTIONS:

1. Parents/guardian should complete sections 1-4; Physician should complete Section 5.
2. When all sections are complete, mail entire application to the **mailing address** above.
3. Please call the Nor-West office to arrange an intake assessment. This 30 minute meeting gives us an opportunity to meet the participant and you a chance to learn more about Nor-West's programs and services.

Please bring a recent copy of the Individualized Education Plan (Youth) or LifePlan (Adult), as well as documentation of developmental disability from OPWDD (ie Determination of Eligibility form).

1. Participant Information: (Please complete ALL sections)

Participant's Name:______________________________ DOB _____/_____/_____ Age:________
Address:____ Apt #:______
City/Town:____NY Zip Code:__________
Participant's Home Phone:____________________ Participant's Cell # ____________________
Are you in the OPWDD system? ________ If yes, please indicate TABS ID#:____________________
Medicaid #_________________SS# _______________HCBS Waiver Enrolled? ___Yes ___No
Medicaid Service Coordinator's Name _________________________ Telephone _______________
Participant's Managed Care Company Name/ID# (If applicable): ______________________________
Self-Direction: _____Yes ________No

Disability Classification: **(Circle all that apply)**

1. Cognitive Impairment (MR)
2. Asperger's Syndrome
3. Cerebral Palsy
4. Autism
5. Pervasive developmental disorder
6. Seizure disorder
7. Neurological impairment
8. Currently unclassified
9. Other: _______________________

Level of self-care: **(Enter appropriate number)**

Eating_________
Dressing_______
Rest Room______
Bus entry/exit_______

1- Completely independent
2- Needs supervision
3- Needs physical assistance
4- Total dependence on staff

Does participant utilize: Wheelchair:_________ Crutches:_________ Braces:__________ Hearing Aid:_______
Sign Language:__________ I-Pad:___________ Other:__________________________

Seizure History: **(Circle all that apply & complete Seizure addendum)**

1. No. seizure history.
2. No seizures in last three years.
3. Currently has seizures with no warning.
4. Currently has seizures; warning signs:__________
5. Seizures well controlled with medication:

Behavioral Issues: **(Circle all that apply)**

1. No issues
2. Physically assaultive
3. Self-injurious
4. Actively resists supervision
5. Extreme mood changes
6. Biting
7. Temper tantrums
8. Hyperactivity
9. Sexual issues

Comments regarding above behaviors:____
____

OPWDD **requires** Nor-West to obtain the following information **(please circle):**

ETHNICITY/ RACE:	1. White 2. Black	3. Hispanic 4. Asian or Pacific Islander	5. Amer. Indian/Alaskan 6. Other
LANGUAGE:	1. English 2. Spanish	3. Other Spoken 4. Sign	5. Other symbolic 6. No language
EDUCATION:	1. Ungraded 2. Grade:____	4. High School 5. Vocational program	6. College courses 7. Unknown

2. Family/Guardian Information:

Father's Name:____
Day Tel. #__________________ Evening #__________________ Cell #______________
Address:________________________________ City:_____________________ Zip:________

Mother's Name:_______________________________________
Day Tel. #__________________ Evening #__________________ Cell #_____________
Address:________________________________ City:_____________________ Zip:________

Guardian/Spouse:____
Day Tel. #__________________ Evening #__________________ Cell #______________
Address:________________________________ City:_____________________ Zip:________

If parent/guardian is **unreachable in case of emergency**, please list an alternative contact:

Name:_______________________________________ Relationship:___________________________
Day Tel. #___________ Evening #___________ Cell #_______
Address:________________________________ City:__________________________ Zip:________

Youth Participant Section: School:__________________________ HR Teacher:________________________
Is school placement: ____Mainstreamed ____ Resource room ____ Self-contained

Adult Participant Section: Work/Day Program:_______________________ Supervisor:____________________
Is setting: ______Competitive employment _______ Day/Com Habilitation
Days___________ Hours ___________

Briefly describe the participant's present living situation. Include level of parental involvement, siblings, peer friendships, etc. If participant lives in a group residence, IRA, or supportive apartment, describe their level of independence.

____
____
____
____
____
____
____
____

3. Medical Authorization:

This application has been completed and the information herein is accurate to the best of my knowledge. The applicant has permission to take part of all Nor-West activities, except as noted by me or by the examining physician.
I understand that every attempt will be made to contact me in case of an emergency. In the event that I cannot be contacted, I give my consent to emergency x-rays, medical treatments, surgery, or dental care for ___________________________

I understand that Nor-West **does not** provide medical insurance for participants.

Signed:____ Date:______________
(Parent/Guardian Signature)

4. Photo/Video Release: Please check one:

_____________I hereby grant permission to Nor-West Regional Special Services to use my son/daughter's likeness, picture, voice, words, or name in either television, radio, film, video, newspapers, magazines, brochures, flyers, website and other media, in any form, for the express purpose of advertising, fund-raising, or communicating the programs of Nor-West.

_____________I **do not** consent to the above photo release.

Signed:____ Date:______________
(Parent/Guardian Signature)

Nor-West Regional Special Services

5. Medical Form: Please have **your physician** complete and sign.

Name:______________________________ DOB:______________ Age:_____ M_____ F_____

I Medical History:

A. Immunizations: If one or more of the required immunizations is contraindicated, Please indicate the reason on the reverse.

DPT (1st)___/___/___ (2nd)___/___/___ (3rd)___/___/___ (Bstr)___/___/___.

Oral Polio (1st)___/___/___ (2nd)___/___/___ (3rd)___/___/___ (Bstr)___/___/___.

Hib (1st)___/___/___ (2nd)___/___/___ (3rd)___/___/___ (4th)___/___/___.

Hepatitis B (1st)___/___/___ (2nd)___/___/___ (3rd)___/___/___ (4th)___/___/___.

MMR (1st)___/___/___ (2nd)___/___/___.

Other (List Type) ______________________________ ___/___/___

Other (List Type) ______________________________ ___/___/___

B. Test Results:

Tuberculin:________________ Urine:________________ HCT:________________

Other tests:____

C. Indicate history/dates of the following (if applicable):

Measles:________ Mumps:____________ Chicken Pox:____________ Hepatitis:______________

Allergies:______________________ Seizures:______________________

D. Medication: Please let us know what medication(s) you take regularly. Attach sheet if needed.

Medication:______________________ Dosage:________________ Time:________

Medication:______________________ Dosage:________________ Time:________

Medication:______________________ Dosage:________________ Time:________

II. Physical Examination:

Primary Diagnosis:______________________ Secondary Diagnosis:______________________

Height:________ Weight:________ Blood Pressure:__________ Heart:_________ Resting Pulse_______

Please indicate the absence of disease or medical issue by writing "WNL" (Within Normal Limits):

Lungs:________ Abdomen:__________ Extremities:__________ Vision:__________ Hearing_______

Skeletal:___ Nose:___________ Throat:_________ Lymph Nodes:___________ Thyroid:___________

Skin:_________ Speech:____________ Ambulation:______________ Balance:________________

Restrictions on physical activity:____

____

______________________________ ______________ ______________

Physician's Signature Date Telephone

Please use this section as necessary to clarify or elaborate medical issues: