



NOR-WEST REGIONAL SPECIAL SERVICES

Participant Application

Mailing Address:
P. O. Box 44
Mohegan Lake, NY 10547
www.nor-west.org

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

INSTRUCTIONS:

1. Parents/guardian should complete sections 1-4; Physician should complete Section 5. (A current physical is acceptable)
2. When all sections are complete, mail entire application to the **mailing address** above or scan to info@nor-west.org.
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
Care Manager's Name _____ Telephone _____
Participant's Care Coordination Company (If applicable): _____
Self-Direction: Yes ____ No ____ Broker Name: _____
Broker Email: _____ FI Name: _____

Disability Classification: (Circle all that apply)

- | | |
|------------------------------|-------------------------------------|
| 1. Cognitive Impairment (ID) | 5. Pervasive developmental disorder |
| 2. Asperger's Syndrome | 6. Seizure disorder |
| 3. Cerebral Palsy | 7. Neurological impairment |
| 4. Autism Spectrum D/O | 8. Currently unclassified |
| | 9. Other: _____ |

Level of self-care: (Enter appropriate number)

- | | | |
|----------------------|---------------------------|------------------------------|
| Eating _____ | 1- Completely independent | 3- Needs physical assistance |
| Dressing _____ | 2- Needs supervision | 4- Total dependence on staff |
| Rest Room _____ | | |
| Bus entry/exit _____ | | |

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. | 4. Currently has seizures; warning signs: _____ |
| 2. No seizures in last three years. | 5. Seizures well controlled with medication: _____ |
| 3. Currently has seizures with no warning. | |

Behavioral Issues: (Circle all that apply)

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

Comments regarding above behaviors: _____

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

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