



CDS Monarch

Celebrating the Everyday of Life

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:

- OMRDD Eligibility Letter
- Waiver Enrollment (NOD)
- Physical (1 year)
- Vocational Assessments (if applicable)
- Current Medication List/Allergies
- Work Restrictions
- PPD/TB test (2 step/ 2 consecutive)
- ISP (Individualized Service Plan)
- IEP (Individualized Educational Program) if applicable
- Photo of Applicant (if available)
- FLDDSO Community Hab Authorization Form (Comm. Hab only)
- Legal Guardianship Papers
- Psychological (most recent)
- Social Work Evaluation (if available)
- DDP2 (2 year)
- Release of Information
- Behavior Support Plan (1 year data collection, if available)
- Level of Care Determination
- IPOP (Individual Protective Oversight Plan) if applicable
- Photo ID

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 to:

Kris Hart, Intake and Development 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) 347-1227 or via email at khart@cdsunistel.org. Again, thanks for your interest in our agency.

Sincerely,

Kris Hart
Intake and Development Coordinator

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: _____

Waiver Enrolled: Yes No NOD date: _____

(NYCARES) New York State Cares Enrolled: Yes No

Service Coordinator: _____

Agency: _____ Phone #: _____

Address: _____

Email: _____ Fax #: _____

School District (if applicable): _____

Contact Name: _____ Phone #: _____

Email: _____ Fax #: _____

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

SERVICES REQUESTED (Check all that apply):

RESIDENTIAL

IRA (Group Home)
Supervised Apartment
Family Care

CASE MANAGEMENT

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

FAMILY SUPPORT

Autism Skill Building Program (6-16)
HCBS Waiver
Sibling Support Group (6-13)
Parent Support Group
Community Habilitation
Recreation (Ages 5 to Adult)
Family Education Training

DAY SERVICES

Individual Placement
Supported Enclaves
Prevoc. Workshop - Blossom
Day Hab/Prevoc-Blended

Day Habilitation
Prevoc. Workshop – Wolf Center/Hard Rd.
Transition Program Services
Vocational or Transition Assessments

Other: _____

PERSONAL PREFERENCES:

Roommate: Yes No Pets: Yes No Smoking: Yes No

Geographic Area: _____ Religious Preference: _____

Special Cultural/Religious Needs: _____

URGENCY OF NEED: Immediate Within 1 year After 1 year

Completed by: _____ Phone #: _____ Email: _____



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Individual's Name: _____

Sex: Male Female

Address: _____

Type of Residence: _____

Phone: _____

Birth date: _____

Social Security #: _____

Medicaid #: _____

Benefits: SSI SSD
Life Insurance Trust Fund
Medicare #: _____

Public Assistance Food Stamps # _____
Burial Fund Tabs #: _____
Medicare Part D Carrier: _____

Spend Down (please describe): _____

Pay Back (please describe): _____

Representative Payee: _____

Disabilities: Mental Retardation Learning Disability Cerebral Palsy
Autism Neurological Impairment Epilepsy (type): _____
Other (specify): _____

Other Medical Conditions:

IQ: _____ DSM Code: _____ Allergies: _____ No Known Allergies

Current Medications (please list)

No

Self-Medicating: Yes No

DNR: Yes No

Health Care Proxy: Yes

Diet: Regular Special (Specific): _____

GUARDIANSHIP / CORRESPONDENTS:

Legal Guardian: _____ Date Established: _____ Not Established

Family/Advocate Contact:

Address: _____

Relationship:

Phone: _____

Email: _____

Alternate Contact:

Address: _____

Relationship:

Phone: _____

Email: _____

Day Program:

Address: _____

Contact:

Phone: _____

SERVICES CURRENTLY RECEIVING (Check all that apply)

RESIDENTIAL

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

CASE MANAGEMENT

Medicaid Service Coordination
 TBI (Traumatic Brain Injury)
 PCSS (Plan of Care Support Services)
 HCBS Waiver
 Parent Support Group

FAMILY SUPPORT

Autism Family Support
 Residential Habilitation (Community)
 Recreation (Ages 5 to Adult)
 Other:

DAY SERVICES SERVICES

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

Individual Placement
 Supported Enclaves
 School
 Transition Program Services

CLINICAL

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

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

MOBILITY STATUS: (Check all that apply)

Ambulatory	Uses manual wheelchair	Able to negotiate stairs
Requires use of lift	One-person transfer	Several person transfer
Able to bear weight	Can be transported in a car	Requires vehicle with lift

ADAPTIVE EQUIPMENT: (Check all that apply)

Communication Device	Wheelchair	Computer	Mobility Device
Eating Utensils	Lift	Hearing Aid	Eye Glasses
Other: _____			

COMMUNICATION:

Primary Language: _____	Requires an Interpreter	Yes	No
Verbal Yes No	Uses sign language	Yes	No

CURRENT SERVICE PROVIDERS: Please refer to Individualized Service Plan for comprehensive list of providers or attach additional sheet.

BEHAVIOR SUPPORT PLAN OR GUIDELINES: Yes (If yes, please refer to BSP/BG) No
 Even if no, please describe any behaviors, safe guards or special needs:

Application Prepared By

Name:

Title:

Date:



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CONSENT FOR RELEASE OF INFORMATION

I, _____ hereby authorize the release of information to CDS Monarch and the Central Entry 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/Central Entry Committee and all of the participating agencies will maintain the confidentiality of this information. CDS, the Central Entry Committee, and all participating agencies will not release this information.

Information to be released: (Please attach all documents)	Date of Form/Assessment	Attached
• OMRDD Eligibility Letter		
• Legal Guardianship Papers		
• Waiver Enrollment (NOD)		
• Psychological (most recent)		
• Physical (1 year)		
• Social Work Evaluation (if available)		
• Vocational Assessments (if applicable)		
• DDP2 (2 year)		
• Current Medication List / Allergies		
• Release of Information		
• Work Restrictions		
• Behavior Support Plan (1 year data collection, if available)		
• IPOP (Individual Protective Oversight Plan) if applicable		
• PPD/TB test (2 step/ 2 consecutive)		
• ISP (Individualized Service Plan)		
• IEP (Individualized Education Program)if applicable		
• Level 1 Assessment/Transition Plan, if applicable		
• Photo of Applicant (if available)		
• LCED		
• FLDDSO Community Hab Authorization Form (Comm. Hab only)		

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 / DEVELOPMENT COORDINATOR.

Kris Hart, Intake and Development Coordinator

860 Hard Rd.

Webster, New York 14580

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

khart@cdsunistel.org