LSE Program Services Application

DDA Waiver:

_____ Community Pathways Waiver

_____ Community Supports Waiver

Services Requested:

_____ Day Habilitation

_____Employment Services

_____ Community Development Services

_____Career Exploration: Facility-based

_____ Career Exploration: Small group

Demographic Information:

Name: ____
(Last) (First) (Middle)

Address: ____
(Street) (City) (State) (Zip)

Home Phone: _______________________ Cellphone: _____________________

DOB: _______________ Sex: ________ SS#: ______________________

Primary Disability: ____

Secondary Disability: ____

Is there a current Behavior Plan? ______ if yes, must be attached for consideration into the program

Has the individual had a Behavior Plan in the last 3 years? _____ if yes, must be attached for consideration into the program

If there is no Behavior Plan please answer the following questions:

Is there any negative behavior that staff should be aware of?
____

____

If yes, what strategies are effective in helping individual with this behavior?

____

Who does the individual reside with: ______Parents _____Mother _____ Father
_____Relative _____ Agency _______ Self _______Other

Primary Caregiver's Name: ___________________________ Phone: ____________________
Email address: _____________________________________

If there is a legal guardian please provide information below and attach guardianship paperwork:
Legal guardian name: ____________________________ Phone: _______________________

Address: ____
(if different from above) (Street) (City) (State) (Zip)

Email Address: _______________________________

Next of Kin:
Name: __________________________ Address: ____________________________________

Phone: _____________________ Cell: __________________ Relationship: _________________

Emergency Contacts:
Name: __________________________ Address: ____________________________________

Phone: _____________________ Cell: __________________ Relationship: _________________

Name: __________________________ Address: ____________________________________

Phone: _____________________ Cell: __________________ Relationship: _________________

Other agencies involved with individual:
Name of program Contact Person Phone

__________________________ ____________________________ __________________

__________________________ ____________________________ __________________

__________________________ ____________________________ __________________

Transportation:
Is transportation needed for this individual: ______ yes _______ no

Can individual use public transportation: ______ yes _______ no

Does individual use wheelchair: ______ yes _______ no

Special accommodations: ____

____

Communication:
______ communicates in full sentences ______ uses sign language

______ follows simple verbal commands ______ able to follow simple written directions

______ uses communication device

Eating Habits:
______ independent ______ requires assistance with set up/heating meals

Toileting:
______ Independent ______ Continent ______ periodic Incontinence

______ requires prompting – timing ______ requires prompting - hygiene

______ requires Assistance with transfers ______ requires Full Assistance

______ uses adult incontinence pads or underwear

Mobility:
______ walks independently ______ uses cane ______ uses walker

______ needs assistance when walking ______ needs assistance with transfers

_____ uses wheelchair at times _____ uses wheelchair at all times _____ uses scooter

Assistance requested as follow: ____

____

Personal:
Is the Individual social? ____
Does he/she smoke? ____
Are there any fears we should be aware of? _______________________________________
Please describe the individual's personality traits: __________________________________
____

Health/Medical information:
Diagnosis: ____
____

Food or Medication Allergies:
Allergy: _______________________ Reaction: _____________________________
Allergy: _______________________ Reaction: _____________________________
Current Weight: ______lbs Special Diet: _____________________________________

Medication Administration:
_____ Self-Administers _____ needs prompting _____ cannot self medicate

Current Medications: Please list or attach PMOF
Name: _______________________ Dosage: __________ Frequency:____________
Reason for medication: ___________________________
Name: _______________________ Dosage: __________ Frequency:____________
Reason for medication: ___________________________
Name: _______________________ Dosage: __________ Frequency:____________
Reason for medication: ___________________________
Name: _______________________ Dosage: __________ Frequency:____________
Reason for medication: ___________________________

Any history of seizures? _____ Do seizures last longer than 5 minutes? ______
Describe seizures: ____

Adaptive Equipment (helmet, splints, AFO) When Used

___________________________________ ___________________________

Other medical information: ____

____

General Health – please check only those that apply

- Any old scars, bumps or lumps
- History of Sinus Infections
- History of nose bleeds
- Difficulty chewing or swallowing
- Use of dentures or bridges
- History of eye problems
- Use of corrective lenses (glasses)
- Uses of contact lenses
- History of cataracts or glaucoma
- Abnormal sensitivity to light
- Abnormal sensitivity to sound
- History of ear infections
- Uses hearing aid ______ Lt _______ Rt
- History of pneumonia or bronchitis
- Difficulty breathing (asthma, COPD, wheezing)
- History of stomach ulcers, vomiting blood
- History of Reflux
- History of constipation or diarrhea
- History of urinary tract infections
- Incontinence
- History of fainting or loss of consciousness
- History of cognitive disturbances (memory loss, hallucinations, disorientation)
- History of speech or language dysfunction
- History of fractures
- Spinal deformity
- Chronic back problems
- History of anemia
- History of easy bruising
- Any open sores, wounds or rashes on body
- Heat or cold intolerance

Other pertinent information:

____

____

Signature Section

Signature of applicant: ______________________________ Date: ______________

Signature of person completing form: ____________________ Date: ______________

Signature of legal guardian: ___________________________ Date: ______________

Approval Section

____________________________________ ________________________

Case Manager Date

____________________________________ ________________________

Program Director Date

____________________________________ ________________________

CEO Date