GATEWAY
HUDSON VALLEY

1 Amy Kay Parkway
Kingston, NY 12401
(845) 331 1261 x248
(845) 331-2112
TBelfiglio@ghv.org

GROUP DAY HABILITATION
APPLICATION

Attached is an application for Gateway Hudson Valley Group Day Habilitation Program.

Day Habilitation Requirements:

Eligibility:

- Primary Diagnosis – Intellectual and/or Developmental Disability (I/DD)
- 18 years of age or older
- Self toileting
- Self ambulating
- Waiver enrolled (private pay option)
- Individual has chosen to participate in Gateway Hudson Valley Day Habilitation Program

Documents (to be included with completed application):

- Completed application
- Most current psychological report
- Health History & Most recent physical exam *(forms attached)*
- Self-Medicating Evaluation *(form attached)*
- Medication Communication *(form attached)*
- Documentation of most recent tuberculosis (Mantoux) test results (2X within 1 year period)
- Care Manager's Participation Agreement *(attached to application)*
- Jonathan's Law Notification Information *(attached to application)*
- Notice of Liability for services *(attached to application)*
- From Care Manager, copy of current
    1. Life Plan/Individual Service Plan (covering period of intake)
    2. Individual Plan of Protective Oversight (IPOP) (if applicable)
    3. Notice of Decision (NOD) pages 1 & 2
    4. Legal Documentation of Guardianship (if applicable)
    5. Level of Care Eligibility Determination (LCED)
- Current day program information if any i.e. - Progress Note and Vocational Treatment Plans for the past six months.

Please return to:

Tina Belfiglio, Manager, Waiver Services
Gateway Hudson Valley
1 Amy Kay Parkway
Kingston, NY 12401

If you have any questions please feel free to contact me at 331-1261 ext. 248, FAX # 331-2112,
E-mail address: tbelfiglio@ghv.org

GATEWAY HUDSON VALLEY
GROUP DAY HABILITATION

Application for Day Hab: Without Walls_____ Site-based _____

Date: _____

Individual: _____ Social Security #: _____

Address: _____

_____

Phone: _____

Date of birth: _____ Male: _____ Female: _____

Medicaid # _____ Medicare# _____

Other Insurance _____ Insurance # _____

Care Manager: _____Agency:_____

Address: _____

Phone: _____

Application Completed by: _____

Emergency contact name: _____

Address & Phone: _____

_____

Is individual presently taking medication? _____Yes _____ No
(If yes, please be sure to fill out all medications on the Medication Communication Form)
1) Waiver enrolled? _____Yes _____No _____In process

2) Type of residence *(circle one)*

ICF C.R. F.C. Supervised Apts. IRA Natural Family Other *(please specify)*

Name_____

3) Diagnosis:

- Primary- IQ-

- Secondary-

4) Does the individual currently receive services from Gateway Hudson Valley?

If so, please identify _____

_____

5) Describe the type of day program the individual now attends:

_____

6) List the needs currently not met in the day program *(please comment)*

_____

_____

_____

7) What daily activities (needs) would the individual like to have met? *(Please comment)*

_____

_____

7a) How would you like the above activities/needs met?

_____

_____

8) Is the individual currently happy with his/her day program? _____Yes _____No

- If no, add additional comments not stated in #6 & #7?

_____

_____

_____

- If yes, why the need for a new program?

_____

_____

9) Please check the areas that the individual would be interested in:

Community Participation_____ Arts & Crafts_____

Recreation_____ Money Management_____

Volunteer work _____ Domestic tasks _____

Mobility _____ Other_____

10) How many days per week would the individual like to participate in program?_____

11) Please identify what day's individual is able to attend program? *(Please circle)*

Monday Tuesday Wednesday Thursday Friday

12) Level of supervision

_____ 1:1

_____Small group - can get along

_____Large group - can get along

Please Comment:_____

_____

_____

13) Please feel free to make any other comments that would help Gateway Hudson Valley Group Day Habilitation in programming for this individual.

_____

_____

_____

_____

_____

Signature/*Title of* ***Date***

Individual Completing Application

Health History

Name: _____ Date: _____
Physician's Name: _____ Physician's Phone #: _____
Medicaid Number: _____ Other Ins Name/No: _____

Medical Diagnoses

_____ _____
_____ _____
_____ _____
_____ _____

Medical Conditions (check all that apply)

- □ Diabetes
- □ Cancer/Tumor
- □ TB
- □ Emphysema
- □ Chronic Bronchitis
- □ Seizures
- □ High Blood Pressure
- □ Low Blood Pressure
- □ Headaches
- □ Dizziness/Fainting
- □ Chronic Cough
- □ Ear Diseases
- □ Thyroid Disease
- □ Rheumatic Fever
- □ Circulation
- □ Varicose Veins
- □ Bowel/Rectal
- □ Hay Fever
- □ Kidney Disease
- □ Bladder Disease
- □ Muscle Disease
- □ Liver Disease
- □ Stomach
- □ Tonsillitis
- □ Appendicitis
- □ Hernia/Rupture
- □ Back Injury
- □ Difficulty Lifting
- □ Arthritis
- □ Bursitis
- □ Fractures
- □ Hepatitis
- □ Visual Impairment

If you have or have had any of the above conditions in the past, please explain:

_____
_____
_____

Surgeries:

_____
_____
_____

Hospital Admissions:

_____
_____

Current Medications (prescription details)

_____ _____
_____ _____
_____ _____

Allergies

_____
_____
_____
_____

Misc.

Tetanus Date: _____
TB Test Results: Neg _____ Pos _____
Chest X-Ray (if necessary) _____

Are there any pre-existing conditions which might impede physical work (i.e., back injury, dizziness, cardiac condition, seizures)? Please describe:

_____
_____
_____
_____

Signature: _____ Relationship to Trainee: _____ Date: _____

Basic Physical Examination *(to be completed by Physician)*

Name: _____ Date: _____
Address: _____

Sex: _____ Age: _____ Height: _____
Weight: _____ B/P: _____ Pulse: _____
Respiration: _____ Temp: _____

Current Medications:

_____
_____
_____

Allergies:

_____
_____
_____

Eyes: _____
Ears: _____
Nose: _____
Neck: _____
Lymphatic Sys: _____
Chest/Lungs: _____
Cardiac: _____
Abdomen: _____
Hernia: _____
Genito-Urinary: _____

Ano-Recto _____
Neurological: _____
Musculo-Skeletal: _____
Extremities: _____
Circulatory: _____
Vision (L): _____ Vision (R): _____
Hearing (L): _____ Hearing (R): _____
Mouth: _____
Breast: _____
Gynecological: _____

Lab Work:

Hepatitis: _____ Urinalysis: _____
SpGR: _____ Albumin: _____
Sugar: _____ CBC (if necessary) _____ VDRL (if necessary _____

PPD

Date of Test		Material Used		Site of Test		Administered By	
Date of Reading		Induration		Erythema		Read By	

INTERPRETATION: _____
IF SIGNIFICANT, PLAN FOR FOLLOW-UP? _____

Physical Limitations:

_____ No _____ Limitations _____ Avoid

Physical Activities:

_____ Walking _____ Standing _____ Stooping _____ Kneeling
_____ Lifting _____ Reaching _____ Pushing _____ Pulling
Other: (specify) _____

Working Conditions:

Outside _____ Inside _____ Humid _____ Dry _____ Dusty _____
Sudden Temperature Changes: _____ Other: _____

Summary:

_____

Recommendations:

_____

Physician Name: _____ Signature: _____ Date: _____
Address: _____ Phone Number: ( ) _____

GATEWAY HUDSON VALLEY
EVALUATION OF INDIVIDUAL'S ABILITY TO SELF-MEDICATE

INDIVIDUAL'S NAME: DOB:

FACILITY: DATE OF EVALUATION:

STANDARD	UNABLE TO PERFORM	PHYSICAL OR VERBAL PROMPT NEEDED	CAN PERFROM WITHOUT ASSISTANCE	COMMENTS
WILL RESPOND WHEN NAME IS CALLED				
COMES TO MEDICATION AREA AT APPROPRIATE TIME				
CAN TELL WHAT TIME HE/SHE TAKES MEDICATION AND TELL THE PRESENT TIME				
CAN NAME MEDICATION HE/SHE IS TAKING AND WHAT MEDICATION IS FOR				
CAN STATE ONE/TWO SIDE EFFECTS WHICH COULD OCCUR AND WHAT HE/SHE WOULD DO IF SAME OCCURRED				
IDENTIFY HIS/HER OWN MEDICATION CONTAINER/BLISTER PACK				
REMOVE THE CORRECT DOSAGE FROM THE BLISTERPAK/CONTAINER AND CLOSE CONTAINER IF NECESSARY				
OBTAIN APPROPRIATE AMOUNT OF FLUID TO SWALLOW MEDICATION				
CAN PUT OWN MEDICATION IN MOUTH				
WILL SWALLOW OWN MEDICATION WITHOUT PROMPTING				
REPLACE MEDICATION IN APPROPRIATE STORAGE AREA				
THROW USED CUP(S) AWAY APPROPRIATELY				

Based upon the observations noted, make a decision as to which category the consumer falls into and document level of ability on Nursing Assessment Summary below.

The above consumer was evaluated and found to be:

( ) 1. **Capable of Self-Administration of Medication Independently** – Can consistently self-administer medication. Supervision and/or assistance may be needed in exceptional circumstances. (Consumer is totally responsible for medication).

( ) 2. **Capable of self-Administering of Medication with Supervision** – Can self-administer medication with occasional prompting and/or instruction and/or monitoring. (Consumer will pour medication and self-administer).

( ) 3. **Capable of Self-Administering of Medication with Assistance** – Can self=administer medication with frequent or regular verbal prompting and /or instruction or frequent physical aid. (Staff will pour medication and give to the consumer for self-administration).

( ) 4. **Total Support** – Total responsibility must be assumed by a licensed nurse or approved medication administration personnel to administer medication to the consumer.

_____ _____
Nurse's Signature Date

Name _____ Date _____

GATEWAY HUDSON VALLEY
MEDICATION COMMUNICATION

Please provide a list of all current medications the individual currently takes.

Medications	Dose	Times	Purpose	Physician

Please note if there have been any hospitalizations, medical problems, or new medical conditions in the past six (6) months.

_____
_____
_____
_____
_____

CARE MANAGER PARTICIPATION AGREEMENT

To: Tina Belfiglio, Manager, Waiver Services, Gateway Hudson Valley

From:

Re: Group Day Habilitation

This is to inform you that I am in agreement with *(individual's name)*_____

attending the Gateway Hudson Valley Group Day Habilitation Site-based _____/Without Walls _____Program on a _____day/(s) per week basis.

_____
Care Manager Signature

_____
Agency

_____
Date