TRINITY ASSISTANCE CORPORATION

Return Application to:
Trinity Assistance Corporation
3545 Buffalo Road, Ste. 2
Rochester, NY 14624
Fax: (585) 978-3555

Community Program Intake Application

- ☐ Hourly Respite-Inhome
- ☐ Hourly Respite-Medically Fragile
- ☐ Community Habilitation
- ☐ Supported Employment
- ☐ Medicaid Service Coordination
- ☐ Fiscal Intermediary Services/Self-Directed
- ☐ Individualized Supports & Services (Housing Subsidy)
- ☐ Housing Options through Trinity

Please complete all sections of this application and do not leave any blanks. *Please print.*

Payment Method: ☐ Medicaid (HCBS Waiver) ☐ Self-directed Plan ☐ Family Reimbursement

1. Consumer Information:

Consumer Name: Last: _____ First: _____

Date of Birth: Mo/Day/Year [_____] [_____] [_____]

Sex: [___] Male [___] Female

Medicaid Number: _____ *TABS #:* _____

Current Address: Street: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____ *Email*: _____

Other Insurance: _____

2. In case of emergency, the following person(s) are to be called:

Name: Last: _____ First: _____

Relationship: [___] Parent [___] Guardian [___] Other

Current Address: Street: _____

City: _____ State: _____ Zip: _____

Preferred Phone: (_____) _____ *Secondary Phone:* (_____) _____

If unable to reach, call:

Name: Last: _____ First: _____

Relationship: [___] Parent [___] Guardian [___] Other

Current Address: Street: _____

City: _____ State: _____ Zip: _____

Preferred Phone: (_____) _____ *Secondary Phone*: (_____) _____

3. Primary Language (communication skill) **Secondary Language (communication skill)**

[___] English
[___] Spanish
[___] American Sign Language
[___] Symbolic (Type: _____)
[___] Communication Device (Type:_____)
[___] Non-verbal
[___] Other _____

[ ] English
[ ] Spanish
[ ] American Sign Language
[ ] Symbolic (Type: _____)
[ ] Communication Device (Type:_____)
[ ] Non-verbal
[ ] Other _____

4. Does this consumer have a court appointed guardian or custodian? [___] Yes [___] No If yes, please list below and attach documentation:

Name: Last: _____ First: _____

Current Address: Street: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____ *Email*: _____

5. Primary Health Care Provider
Primary Physician: _____

Address: Street: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____ *Fax:* (_____) _____

Hospital Affiliation /Emergency: _____

6. Does this consumer have any known allergies, for example, to foods, medications, or the environment?
[___] Yes [___] No If yes, please list below include date and reaction:

_____

_____

_____

7. Has this consumer ever had a seizure? [___] Yes [___] No If Yes, please answer the following:
a. When was the last time the consumer had a seizure? _____

b. How often does the consumer have a seizure? _____

c. Please describe as fully as possible, a typical seizure episode, including physical characteristics, and duration. Describe any warning signs that a seizure is about to occur.

_____

_____

8. Medicaid Service Coordinator:

*Name:*_____ *Agency:* _____

Address: Street: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____ *Email:*_____

9. Describe the reason(s) this consumer is requesting services from Trinity Assistance.

_____

_____

10. Describe this consumer's disability history. Please include any special medical issues in the history.

Primary Diagnosis _____

Secondary Diagnosis _____

Comprehension Ability:
[___] comprehends verbal directions without problems
[___] understands simple directions
[___] does not understand simple directions
[___] other, please describe: _____

_____

11. Does the consumer demonstrate any of the behaviors below?

Behavior	Yes	No	Daily	Weekly	Monthly
Physical Aggression					
Verbally Aggressive					
Wandering/Running Away					
Destroys Property					
Tantrum					
Self-Injurious					
Mouthing/Swallowing non-food items					
Inappropriate interactions with others					
Other:					

12. Does the consumer have a current written behavioral plan? [___] Yes [___] No If Yes, please attach a copy of the most current plan.

13. School/Program Information:
Is the consumer attending school or a day program? [___] Yes [___] No If Yes, please complete below.

School or Program Name: _____

Contact Name: Last: _____ First: _____

Address: Street: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____ *Email:* _____

14. Mobility Information:

Mobility Type:	**Yes**	**No**	**Assistance Needed/Type:**
Does this individual walk independently?			
Does this individual use aids for mobility? *(example, walker, rolling walker, scooter, cane, etc.)*			**If Yes, please list type:**
Does this individual use a wheelchair?			**If Yes, please answer *a-b.***
a) Does this individual transfer independently?			**If No, describe assistance needed:**
b) Does this individual use aids for transferring?			**If, Yes, please list type:**

15. What is the consumer's evacuation capability? Is the consumer able to leave a building by himself or herself during an emergency? [___] Yes [___] No If *No,* what type of support/assistance is needed?

_____

_____

16. Is this consumer continent of bowel? [___] Yes [___] No

Is this consumer continent of bladder? [___] Yes [___] No

If No to either question, please describe toileting needs and routines, including the use of adult continence products.

_____

_____

Will the consumer ask for toileting assistance? [___] Yes [___] No

Will the consumer be aware if he or she is incontinent? [___] Yes [___] No

17. Please list the type and use of all adaptive equipment used by this consumer.
Please include helmets, AFOs, braces, utensils, etc._____

_____

Date of Service Need: _____

Primary Valued Outcomes from Community Hab services: ***(check all that apply)***

[___] Daily Living Skill Building
[___] Health/Personal Care
[___] Communication/Self-Advocacy
[___] Leisure Skills/Community Inclusion
[___] Positive Behavioral Support
[___] Hands-on Assistance as necessary
[___] Community Inclusion
[ ] Travel/Program related transportation
[ ] Adult Educational Supports
[ ] Social Skills/Relationship building
[ ] Money Management
[ ] Life Safety/Protective Oversight
[ ] Professional services as necessary

Printed Name of person completing this form _____

Signature of person completing form _____ Date _____

Relationship to Individual _____

Please attach the following documents to the completed application:

- **Current ISP**
- **Current Psychological Assessment**
- **Current LCED**
- **Copy of DDP2**
- **Copy of Behavior Plan (if applicable)**
- **Completed HIPAA forms**
- **Completed Memorandum of Understanding if Self-directing Respite/ Community Hab**
- **Copy of most current Medication List, including not-medication treatment orders and Medical Diagnoses from Primary Physician.** ***(Only for Respite only)***

Please submit all application materials to:
Trinity Assistance Corporation
3545 Buffalo Road, Ste. 2
Rochester, NY 14624
Phone: 585-861-6817
Fax: (585) 978-3555
Email: community-program@trinityassistance.org