Epilepsy Center of Northwest Ohio
Application for Services

Please indicate which services you are requesting:

☐ WAIVER (W) ☐ ICF/IID (ICF) ☐ RESPITE (R)
☐ ADULT DAY SERVICES/VOCATIONAL (ADS) ☐ NON-MEDICAL TRANSPORTATION (NMT)

Hello and thank you for your interest in The Epilepsy Center of Northwest Ohio. As we evaluate each new contact, there is a variety of information that we request to ensure that we can best meet your needs. Please keep in mind that comprehensive information helps us make an informed decision in our ability to serve you. Omitting information may affect our ability to effectively serve you. All information submitted will be kept confidential.

If you have any questions about the information you requested, please feel free to contact the Program Manager at 419-867-5950. You may also contact your Service and Support Specialist for additional information as some may be in their files as well. All information should be returned to the Program Manager or QIDP at 1701 Holland Rd., Maumee, OH 43537 or faxed to 419-867-5954. Please note that the items below

For Pre-Admission Review

◊ Copy of individual's current Individual Service Plan (ISP) - ALL
◊ List of past known legal problems, past or pending W ICF ADS NMT
◊ Copy of current assessments W ICF ADS NMT
◊ Psychological evaluations W ICF
◊ Social evaluations W ICF
◊ Completed packet (as attached) ALL

Once you have been accepted as a client, we request the following information be submitted prior to admission:

◊ Copy of individual's current Individual Service Plan (ISP) ALL
◊ Current medical examinations completed (within 30 days) (see attached) W ICF ADS NMT
◊ Dental exam must be current (within last 12 months) W ICF ADS NMT
◊ List of upcoming medical/counseling appointments, summary of past appointments for 1 year W ICF ADS NMT
◊ List of appointments to be scheduled W ICF ADS NMT
◊ All immunizations current. Provide documentation W ICF ADS NMT
◊ TB testing (2 step PPD test) (within 30 days) ALL
◊ Current self-medication assessment ALL
◊ Psychological evaluation must be current within last year; attach copy. W ICF ADS NMT
◊ Social evaluation must be current within last year; attach copy. W ICF ADS NMT
◊ State Identification Card ALL
◊ Medicaid and Medicare cards ALL
◊ Birth Certificate ALL
◊ Social Security Card ALL
◊ Life insurance, burial, and funeral policies where available W ICF ADS NMT
◊ A comprehensive possessions inventory W ICF ADS NMT
◊ A minimum 30 day supply of all medications W ICF ADS NMT
◊ Sufficient medications needed for length of stay R
◊ Emergency Services Confirmation Letter (Emergency Respite Only)
◊ CPT revised to include services (Waiver Respite Only)

Office Use

_____ _____

Date received Date added to wait list

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Personal Information

Name of Applicant_____

Address_____

Phone Number:_____ County of Residence_____

Date of Birth_____ M ☐ F ☐ Religion_____

Social Security _____ Marital Status ☐ S ☐ M ☐ W ☐ D

Race PLEASE SELECT Hair Color SELECT Eye Color BLUE

Height 4' 1" Weight_____ Language_____

Name of SASS_____

Supportive Relationships

Responsible Party_____ Relationship_____

Address_____

Home Phone_____ Work Phone_____

Admission from_____

Legal Guardian_____

Address_____

Phone_____

Are there any restrictions currently in place on visitors? ☐ **Yes** ☐ **No**

If yes, Please provide additional documentation as to who is not allowed contact, why and who has requested this.

_____

_____

Emergency Contacts

Name_____ Relationship_____

Address_____

Home Phone_____ Work Phone_____

Name_____ Relationship_____

Address_____

Home Phone_____ Work Phone_____

Family Contacts

Name_____ Relationship_____

Address_____

Home Phone_____ Work Phone_____

Medical Information ALL

Diagnosis:_____

_____

_____

Past surgeries:_____

_____

Medications/
Treatments:_____

_____

_____

Special Medical Equipment:_____

_____

Allergies:_____

_____

Hospital of
Choice:_____

Primary Care Physician: ALL

Name_____ Phone_____

Address_____

COMPLETED SELF-MEDICATION ADMINISTRATION ASSESSMENT (upon intake only) W ICF ADS NMT

Financial W ICF R

SSI – Amount_____ SSA – Amount_____

Waiver – Name_____ Other _____

Medicare #_____ Medicaid #_____

Insurance Company _____

Policy #_____

Contact #_____

Developmental Abilities

Ambulation

- ☐ walks alone
- ☐ walks with assistance
- ☐ sits alone
- ☐ sits with support in special chair

Eating

- ☐ drinks independently
- ☐ drinks from cup with assistance
- ☐ eats independently with utensils
- ☐ eats using fingers/hands
- ☐ fed by other than oral means
- ☐ eats with assistance
- ☐ needs to be fed
- ☐ chews, eats regular food
- ☐ needs special diet

Toileting

- ☐ uses bathroom independently
- ☐ indicates needs to use bathroom
- ☐ incontinent, wears briefs
- ☐ able to use bathroom during day
- ☐ uses urinal/bedpan
- ☐ constipation is a problem
- ☐ able to use bathroom during night
- ☐ wipes independently
- ☐ needs assistance with wiping

Dressing

- ☐ dresses independently
- ☐ dresses with assistance
- ☐ needs assistance with fasteners
- ☐ needs complete assistance

Personal Hygiene

- ☐ bathes/showers independently
- ☐ brushes teeth independently
- ☐ needs assistance with tooth brushing
- ☐ needs bathing/showering assistance

Communication

- ☐ uses speech to communicate
- ☐ uses some words/phrases
- ☐ gestures/vocalizes
- ☐ uses a communication board/device
- ☐ understands simple requests
- ☐ no effective communication

Sleeping

- ☐ sleeps in bed with side rails
- ☐ sleeps in bed with alarm
- ☐ does not sleep through the night
- ☐ sleeps through night

What supervision level does the applicant need in their own home in:

The kitchen: _____

The living area: _____

The bathroom: _____

While sleeping: _____

Behavior Concerns

Does the applicant have any of the following behavioral concerns?

☐ Aggression ☐ AWOL ☐ Sexual Deviance ☐ Self-injury ☐ Other behavioral issues

If you marked any of the above, please explain the applicant's behavioral concerns, frequency, and intensity as well as any interventions used:

_____

_____

_____

_____

Does the applicant have a behavior support plan in place? ☐ Yes ☐ No

Day Programming

Is the individual currently enrolled in a day program/employment? ☐ Yes ☐ No

If yes, where?

_____

Supervisor's/Contact

Name_____

Address_____

Phone_____ Fax_____

Email_____

Please note any additional information that you think would be helpful for us to know to provide services to the applicant:

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