

**Cerebral Palsy of Ulster County Inc.**  
**P.O. Box 1488 / Kingston, NY 12401**  
**Phone: (845) 336-7235 Fax: (845) 336-7248**

## **INSTRUCTIONS TO RESIDENTIAL** **APPLICATION**

Please mail all applications to:

Dana Pavelock  
c/o Cerebral Palsy of Ulster County Inc.  
P.O. Box 1488  
Kingston, NY 12402

For inquiries, call (845) 336-7235

If you have any of the following information available, please include it with the application:

1. Most recent physical examination with PPD status.
2. Current psycho-social evaluation
3. Current psychological evaluation with IQ
4. Most recent IEP, ISP, or CFA information
5. OMRDD eligibility
6. NOD/LOCD

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## APPLICATION FOR RESIDENTIAL SERVICES

### Referral Form

1. Applicant's Name: \_\_\_\_\_ 2. D.O.B.: \_\_\_\_/\_\_\_\_/\_\_\_\_
3. Referral Source: \_\_\_\_\_  
Contact Person: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_
4. Type of Referral Source:  
(Check one.)  
 Self Referral  
 Family  
 Private Agency  
 D.D.S.O
5. Referral Date: \_\_\_\_/\_\_\_\_/\_\_\_\_
6. Present Placement:  
Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Phone number: \_\_\_\_\_
7. Type of Present Placement: (Check one.)  
 Home  
 ICF (Intermediate Care Facility)  
 DC (Developmental Center)  
 CR (Community Residence)  
 Other: \_\_\_\_\_
8. Place of Birth: \_\_\_\_\_ 9. Social Security #: \_\_\_\_\_
10. a.) SSI:    yes / no                      10. b.) SSA/SSD:    yes / no
10. c.) Other Benefits:    Railroad / Veterans / 620-621 \_\_\_\_\_
10. d.) Medicaid #: \_\_\_\_\_ 10. e.) County: \_\_\_\_\_
10. f.) Medicare #: \_\_\_\_\_ 10. g.) U.S. Citizen:    yes / no
11. Developmental Disability: (Check all that apply.)
- |   |  |  |
|---|--|--|
| <input type="checkbox"/> None               | <input type="checkbox"/> Seizure Disorder    | <input type="checkbox"/> Neurological Impairment |
| <input type="checkbox"/> Mental Retardation | <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Unknown                 |
| <input type="checkbox"/> Autism             | <input type="checkbox"/> Cerebral Palsy      |  |
12. Primary Disability: \_\_\_\_\_



2. \_\_\_\_\_ Total support (staff/parent assumes total responsibility for administering medications)
3. \_\_\_\_\_ Assistance (staff/parent keeps medication and gives to client for self administration)
4. \_\_\_\_\_ Supervision (client keeps own medication, but needs verbal prompts from staff/parents)
5. \_\_\_\_\_ Independent (client is totally responsible for medication)

e.) Indicate whether or not client:

1. Missed more than two (2) weeks of Day Programming in the last year? yes / no

If Yes, Explain: \_\_\_\_\_  
 \_\_\_\_\_

2. Was hospitalized for medical problem in the last year? yes / no

If Yes, Explain: \_\_\_\_\_  
 \_\_\_\_\_

3. Requires staff to be trained in special health care procedures? yes / no

If Yes, Explain: \_\_\_\_\_  
 \_\_\_\_\_

4. Requires special diet? yes / no

If Yes, Explain: \_\_\_\_\_  
 \_\_\_\_\_

18. Other deficits: (Please specify - no deficit, mild deficit, moderate deficit, severe deficit, profound deficit, undetermined.)

a. Hearing: \_\_\_\_\_

b. Vision: \_\_\_\_\_

c. Communication: \_\_\_\_\_

d. Activities of Daily Living/Self Care: \_\_\_\_\_

e. Independent Living: \_\_\_\_\_

f. Behavior: \_\_\_\_\_

19. Additional comments on deficits:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

20. Court appointed guardian or legal status: \_\_\_\_\_

21. Guardian: (if applicable) Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

22. Correspondent: Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

23. a. Have you ever been convicted of a crime? If yes, please explain the nature of the crime.

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23. b. Do you currently have restrictions resulting from the above? If yes, please explain.

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24. What services are you currently receiving and from whom?

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25. Do you have a service coordinator/case manager? yes / no

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

26. What services are you interested in? (Check all that apply.)

- Service Coordination
- Occupational Therapy
- Physical Therapy
- Speech
- Psychology
- Social Work
- Day Treatment
- Supported Employment
- Residential
- Audiology
- Neurology