NEW YORK STATE OF OPPORTUNITY. Office for People With Developmental Disabilities

**ATTACHMENT A**

# Intensive Behavioral (IB) Services Application Form

**Instructions:** Individuals must be HCBS Waiver enrolled to be eligible for IB Services. If the participant is not enrolled in the HCBS Waiver, contact the local DDRO before submitting this application. Please complete application in its entirety, incomplete applications cannot be accepted. The referring party must sign and date this application form before submission. Submit the completed application, including supporting documentation, to the liaison at the individual's local Developmental Disabilities Regional Office (DDRO).

***Check if this is an initial application or a reauthorization request for additional hours of service:***

- ◯ Initial Application
- ◯ Reauthorization Request; initial authorization date: _____

## *SECTION I- Referring Party*

Name of Person Completing the Application:_____

Affiliation (e.g., agency name/title/relationship to individual):_____

Phone Number:_____ Email Address:_____

## *SECTION II- Applicant*

Name:_____ Date of Birth:_____ TABS ID:_____

Street Address:_____ City:_____ Zip Code:_____

Individual's Phone Number (or Parent/Guardian):_____

CIN:_____ ◯ ◯

Name of school, if currently enrolled:_____

Living Arrangement:

- ◯ Lives Independently
- ◯ Lives with Family
- ◯ Family Care Home
- ◯ Lives with Roommate(s)/Significant Other
- ◯ Other:_____

## *SECTION III- Current Supports & Services*

### *1. Check all OPWDD Services currently received:*

- ☐ Group Day Habilitation
- ☐ Day Habilitation WOW
- ☐ Respite
- ☐ CSIDD
- ☐ Pre-Vocational Services
- ☐ Supported Employment
- ☐ Individual Support Services
- ☐ Community Habilitation
- ☐ Family Education Training
- ☐ Family Support Services
- ☐ Other:_____

***2. Check all clinical services currently received:***

☐ Psychological Services ☐ Speech Therapy ☐ Other:_____

☐ Occupational Therapy ☐ Physical Therapy

***3. List any other services the individual is currently receiving:***

***4. List all medication(s) the individual is currently prescribed, including dose(s), indicate compliance and effect:***

***SECTION IV- Supporting Information***

***1. Provide a summary of the individual's behavioral concerns that would be addressed through IB Services. Include a description of how the behaviors have put the individual at imminent risk for losing his/her/their current residence. If this is for re-authorization for additional hours within an authorized period, provide justification for the additional IB Services.***

***2. Please check all supporting materials included in the application:***

☐ Recent CANS-NY or CAS Summary *(required)* ☐ Life Plan *(required)*

☐ Clinical records (e.g., psychological assessments) ☐ Behavioral Data

☐ Psychosocial assessments

☐ School records (e.g., Behavior Intervention Plan, Individualized Education Program, 504 Plan)

☐ Previously completed Functional Behavior Assessment(s) and Behavior Support Plan(s)

☐ Other materials:_____

***3. Documentation that substantiates the individual is at risk of imminent placement into a more restrictive residential setting due to identified challenging behavior(s) is required:***

◯ Included

◯ Not Included

_____ _____

***Signature of Person Completing this Application*** ***Date of Signature***