Department of Community Mental Health
112 East Post Road, White Plains, NY 10601 914-995-5244

Dear Parent, Guardian and/or Advocate,

It is to my understanding that you are interested in exploring residential services for an individual through the Westchester County Department of Community Mental Health. Westchester County DCMH is the central point of intake for the NYS-Cares list.

In order to add an individual to the NYS-Cares residential waiting list, please submit the following documentation:

- ❑ Current ISP
- ❑ Current IEP
- ❑ Psychological Evaluation
- ❑ Psychiatric Evaluation
- ❑ Psychosocial
- ❑ Annual Physical
- ❑ Consent Form - attached
- ❑ Primary and Secondary Contact Information for Consumer
- ❑ Westchester County Registration Form - attached
- ❑ DDP4 - attached

Once I have received the material, along with a completed Developmental Disabilities Profile (DDP4) I will process the material, so that the individual may be placed on the NYS-Cares waiting list. You should expect a residential survey call from the Hudson Valley DDSO. This process can take any where from 4-6 weeks. Once an individual has been placed on the NYS-Cares waiting list, DCMH will have the opportunity to refer the packet to possible vacancies that may be available at the appropriate time.

If you have any questions please do not hesitate to call me at 914-995-5276.

Thank you,
Cynthia Lanza,
Residential Case Manager

Please submit your NY Cares Packet to:
Westchester County Department of Community Mental Health
112 East Post Road-2nd Floor
White Plains, NY 10602
Attention: Cynthia Lanza

112 East Post Road
White Plains, New York 10601 Telephone: (914) 995-5276 E-Mail cml2@westchestergov.com

This form is for information purposes only. Completion of this form does not imply eligibility or acceptance for services.

NYS Office For People With Developmental Disabilities
OPWDD Putting People First

CONFIDENTIAL NEEDS IDENTIFICATION
DDP-4

General Instructions:

*Complete for any person who has a developmental disability and has an **UNMET** need for services or supports.* ***Do not*** *use this form to indicate a need to continue or to enhance services/supports now being received.*

MARKING INSTRUCTIONS

- *Use a black or blue pen or a number 2 pencil.*
- *Print clearly using all CAPITAL letters and ARABIC numbers.*

A B C D E 0 1 2 3 4 5 6 7 8 9

Correct Mark ● Incorrect Marks ✓ ⊗

1. Purpose: (Mark one)

○ New Person ○ Review

ITEMS 2-5 MUST BE COMPLETED ON EACH FORM

2. Name of Person in Need: (Please print full name)

Last Name

First Name MI

3. Address of Person in Need:

Address

City

State Zip Code

➔ ○ Mark here if this is a new address.

County

4. Sex

○ Male
○ Female

5. Date of Birth

Month Day Year

6. TABS (Tracking and Billing System) ID (If known)

7a. Person's Social Security Number

7b. Person's Medicaid Number

8. Name of Agency/Program Reporting Need:

Agency Code **Program Code(s)** (Optional)

Agency or DDSO Staff Member Completing or Consulting on Form:

Last Name

First Name

Phone Number

Area Code

Date Completed

Month Day Year

9. Person's Current Residence Type: (Mark only one)

1 ○ Own home or apartment
2 ○ Shared home with housemates
3 ○ Home of his/her family
4 ○ Local Department of Social Services Residence or Foster Care Home
5 ○ Nursing Facility
6 ○ Homeless or Shelter
7 ○ OPWDD Certified Residence
8 ○ Other (specify):

(If 1, 2, or 3 complete if appropriate)
How old is the primary care giver? Years

10. Ethnicity/Race: (Mark the most appropriate)

1 ○ White
2 ○ Black
3 ○ Hispanic
4 ○ Asian/Pacific Islander
5 ○ American Indian/Alaskan
6 ○ Other

Revised: September, 2010

For information purposes only. Not an application for services.

11. Disabilities: (Mark all that apply)

1 ○ Developmental Delay
2 ○ Mental Retardation
3 ○ Autism
4 ○ Cerebral Palsy
5 ○ Epilepsy/Seizure Disorder
6 ○ Learning Disability
7 ○ Other Neurological Impairment
8 ○ Psychiatric Disability
9 ○ Chronic Physical/ Medical Condition
10 ○ Sensory Impairment
11 ○ Undetermined
12 ○ Other (specify):
13 ○ Brain Injury (TBI)
14 ○ Prader-Willi Syndrome (PWS)
15 ○ Fetal Alcohol Syndrome
16 ○ Narcolepsy
17 ○ Neurofibromatosis
18 ○ (Code Not Valid)
19 ○ Spina Bifida
20 ○ Tourette Syndrome
21 ○ Toxic Substance Exposure

12. Preferred Language: (Mark all that apply)

Spoken	Nonverbal	Understood
1 ○ English	1 ○ Sign	1 ○ English
2 ○ Spanish	2 ○ Other Symbolic	2 ○ Spanish
97 ○ None	97 ○ None	97 ○ None
98 ○ Other	98 ○ Other	98 ○ Other

13. Does this person use a wheelchair on a regular basis (even part-time)? ○ Yes ○ No

*Respond to residential item 14 **only** if there is an **UNMET** need for OPWDD residential services. Otherwise, skip to item #15. It is OK to leave item 14 blank if the item does not apply at this time.* ***Answer 1, 2, or 3.***

14. Residential Support Need: (Mark only one of the following)

1 ○ This person needs to move into a residence that provides 24 hour support. *(Indicate in item 15 which supports, if any, the person needs while waiting for a residence.)*

OR

2 ○ This person needs to move into a residence and receive part-time assistance and/or support. *(Indicate in item 15 which supports, if any, the person needs while waiting for a residence.)*

OR

3 ○ This person needs services/supports at home instead of an alternative residence. *(Indicate in item 15 which supports the person needs instead of an alternative residence.)*

*Indicate **UNMET** need for any of the following OPWDD services. It is OK to leave item 15 blank if the item does not apply at this time.* (Mark all that apply)

15. Individual and Family Need:

Supports

1 ○ In-home residential habilitation services
2 ○ Home Care/Home Maker
3 ○ Recreation
4 ○ Service Coordination
5 ○ Transportation
6 ○ Behavior Management
7 ○ Parent Training
8 ○ Advocacy
9 ○ Sexuality Counseling
10 ○ Future Planning (e.g., guardianship, trusts)
11 ○ Substance Abuse Services
12 ○ Rent Subsidy

Respite

13 ○ Adult/Child care (during working hours, after school)
14 ○ Respite (Day/Evening)
15 ○ Respite (Overnight)

Assistive Technology

16 ○ Adaptive Equipment
17 ○ Environmental modification

*Indicate **UNMET** need for any of the following OPWDD services. It is OK to leave item 16 blank if the item does not apply at this time.* (Mark all that apply)

16. Clinical Service Need:

Rehabilitation/ Habilitation Services

1 ○ Occupational therapy/ assessment
2 ○ Physical therapy/ assessment
3 ○ Psychology
4 ○ Psychiatry
5 ○ Rehabilitation (vocational) counseling
6 ○ Speech pathology
7 ○ Audiology
8 ○ Social Work

Medical/Dental Services

9 ○ Medicine (includes primary care & specialties)
10 ○ Dentistry

Health Care Services

11 ○ Nursing
12 ○ Dietetics and Nutrition

*Indicate **UNMET** need for an Adult Daily Activity. Mark **one** of the following choices. It is OK to leave item 17 blank if the item does not apply at this time.*

17. Adult Daily Activities Need:
The person's *primary* unmet need is for:

1 ○ Supported employment
2 ○ Day habilitation services
3 ○ Prevocational or vocational skills training
4 ○ Day treatment services
5 ○ Senior citizen/geriatric activities

18. This information was provided by the individual or a Family member:

Print name: _____

Relationship: _____

Signature: _____

Phone Number Area Code _____

Westchester gov.com	DEPARTMENT OF COMMUNITY MENTAL HEALTH 112 East Post Road, White Plains, New York 10601 (914) 995-5244

Developmental Disabilities Registration Date: _____

Applicant's First Name: _____ Last Name: _____

Current Address: _____Zip Code: _____

Phone #( ) ____-_____ Date of Birth: _____/_____/_____ Age: _____ SS#____-____-____SSI/D? _____

Private Insurance: Y/N Company/Policy #:_____ Medicaid#: _____

Disability Information (Please check all that apply:)

I.Q.: _____ Level of Mental Retardation: Mild: _____ Moderate: _____ Severe: _____ Profound: _____
Epilepsy/Seizure disorder _____ Cerebral Palsy _____ Autism _____ Neurological Impairment _____
Orthopedic Impairment: _____ Emotional Disability or Mental Health Diagnosis _____
Other: _____ Ambulatory (Y/N) Uses: Wheelchair____ Walker____ Crutches ____Orthotics____
Verbal (Y/N) Adaptive Devices
_____

Relationship of Correspondent (Check One) ☐ **Parent** ☐ **Legal Guardian** ☐ **Advocate**

Name: _____

Address: _____Zip Code: _____

Home Phone: ( ) _____ - _____ Work: ( ) _____ - _____ Cell: ( ) _____ - _____

School or Day Program: _____ Program Contact _____

Phone ( ) _____ - _____ Anticipated Graduation Date: _____

Address: _____Zip Code: _____

Is Applicant Currently seeking services: (Check any that apply)

☐ In-Home Residential Habilitation ☐ Day Habilitation/Day Program ☐ Supportive Employment
☐ Medicaid Service Coordination ☐ Recreation Program ☐ Respite
☐ Individual Support Services ☐ Environmental Modifications ☐ Residential Opportunity
☐ Other (Explain) _____

Department of Community Mental Health
112 East Post Road, White Plains, NY 10601 914-995-5244

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I hereby authorize the release of information from the records of:

_____
Consumer Name

To the Westchester County Department of Community Mental Health, 112 East Post Road, White Plains, NY 10601 for the purpose of arranging needed services. I understand this authorization does give Westchester County Department of Community Mental Health the authority to release said information when there is a need to arrange services on behalf of the above named client.

I understand that I may revoke this consent at any time.

_____
Consumer's Signature

_____
Signature of person authorized to act on behalf of consumer

_____
Relationship of authorized person

_____

_____

_____
Relationship of authorized person

_____
Address of authorized person

Witnessed by: _____
Signature

_____

_____
Address

Date: _____