The Arc
Livingston-Wyoming
New York

Date of Application: ______________
Date Application Received by The Arc: ______________

Application for Hilltop/Community Services

PERSON SEEKING SERVICES

Name: ______________ (Last) ______________ (First) ______ (MI)

DOB: ______________ SS#: ______________ Sex: ☐ M ☐ F

Medicaid #: ______________ Current Residence Type: ______________

Address: ______________

City: ______________ State: ______________ Zip: ______________

Phone: ______________ Cell Phone : ______________ OK to Text? ☐ Yes ☐ No

Email: ______________ Preferred Method of Communication: ______________

OTHER FAMILY / INVOLVED PERSON(S)

Where did you hear about us?

Who is helping you apply for services, if anyone? ______________ Phone : ______________

Do you have a caregiver? ☐ Yes ☐ No If yes, complete the section below:

Name: ______________

Address: ______________

City: ______________ State: ______ Zip: ______ Phone: ______________

Email: Preferred Method of Communication:

Family/Involved Person: ______________

Relationship: ______________

Address: ______________

City: ______________ State: ______ Zip: ______ Phone: ______________

Email: Preferred Method of Communication:

1st Emergency Contact: ______________

Address: ______________

City: ______________ State: ______ Zip: ______ Phone: ______________

Email: Preferred Method of Communication:

2nd Emergency Contact: ______________

Address: ______________

City ______________ State: ______ Zip: ______ Phone: ______________

Email: ______________ Preferred Method of Communication: ______________

Documents Needed

- ☐ Most Recent Psych Evaluation
- ☐ Most Recent Social Evaluation
- ☐ Most Recent Physical
- ☐ Most Recent IEP (as applicable)
- ☐ Eligibility Letter
- ☐ NOD
- ☐ LCED
- ☐ Medication List

DO YOU HAVE A CARE COORDINATOR / MANAGER

Care Coordinator Name: ______________________ Phone #: ____________

Organization: ______________________ Fax#: ____________

Email Address: ______________________

Address: ______________________

City: ______________________ State: __________ Zip: __________

DIAGNOSES

Please provide any Medical, Developmental or Psychiatric Diagnoses:

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Pharmacy:

Hospital Preference:

SERVICE REQUESTED

If known, please indicate below services desired:

VOCATIONAL SERVICES	COMMUNITY SERVICES
☐ Pre-Employment	☐ Day Program
☐ Employment	☐ Community Hab
☐ Volunteer Opportunities	☐ Behavior Supports
☐ Job Training	☐ Recreation
☐ Employment Supports	☐ In Home Respite

What types of supports would help?

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Completed by (Please Print): ______________________ Date: ______________

Please mail completed form to Intake Department, The Arc of Livingston-Wyoming, 18 Main Street, Mt. Morris, NY 14510 or email to outreach@lwarc.org