



Date of Application: _____
 Date Application Received by Arc: _____

Application for Services

PERSON SEEKING SERVICES	Name: _____ Last First MI	
	DOB: _____	SS#: _____ Sex: <input type="checkbox"/> M <input type="checkbox"/> F
	Medicaid #: _____	Current Residence Type: _____
	Address: _____	County: _____
	City: _____	State: _____ Zip: _____
	Phone: _____	Cell Phone : _____ OK to Text? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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: _____	
1 st Emergency Contact: _____		
Address: _____		
City: _____ State: _____ Zip: _____ Phone: _____		
Email: _____ Preferred Method of Communication: _____		
2 nd Emergency Contact: _____		
Address: _____		
City: _____ State: _____ Zip: _____ Phone: _____		
Email: _____ Preferred Method of Communication: _____		
Documents Needed	<input type="checkbox"/> Any Plans Related to Behavior (if applicable)*	
	<input type="checkbox"/> Most Recent Psych Evaluation <input type="checkbox"/> Most Recent IEP (as applicable) <input type="checkbox"/> Eligibility Letter <input type="checkbox"/> LCED (current) <input type="checkbox"/> Exit Summary if Transitioning Student	
<input type="checkbox"/> Life Plan (most recent)*		
<input type="checkbox"/> HCBS Waiver NOD*		
<input type="checkbox"/> Most Recent Physical with medication list*		
<p><small>*These documents are required for Arc GLOW Admissions Teams review to occur – a person’s information will not go to them until all are received.</small></p> <p style="text-align: right;"><small>These documents are also needed and will be most helpful to have at the same time</small></p>		

Application for Arc Services

(continued)

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:		
	COVID Vaccinated:	Booster/s:	Please provide a copy of your vaccine card/s with your documents
	Pharmacy: _____		
Hospital Preference: _____			
Physician: _____			

Self-Direction	Are you participating in Self-Direction? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Name of Broker/contact: _____	Name of FI/contact: _____

SERVICE/S REQUESTED	<u>Please indicate services of interest:</u>	
	DAY & VOCATIONAL SERVICES	COMMUNITY & Other SERVICES
	<input type="checkbox"/> Site based Day Habilitation <input type="checkbox"/> Community based Day Hab <input type="checkbox"/> Site Based Pre-Vocational Programs <input type="checkbox"/> Community Pre-Vocational Programs <input type="checkbox"/> Supported Employment <input type="checkbox"/> Mental Health Employment Supports These programs require admissions team review. Specific Program Requested: _____ If LIVES, additional application materials are needed.	<input type="checkbox"/> Community Habilitation <input type="checkbox"/> Behavior Supports <input type="checkbox"/> Recreation <input type="checkbox"/> In Home Respite <input type="checkbox"/> Family Support Autism Support (maybe FSS general) <input type="checkbox"/> Self-Direction Specific Program Requested: _____ If behavior supports, additional application materials are needed.
	What types of supports would help?	

This form **does not** require a signature.

Completed by (Please Print): _____ Date: _____

Please e-mail completed form with documents to jangililli@lwarc.org Intake Department, Arc GLOW, 18 Main Street, Mt. Morris, NY 14510. Thank you so much for this referral. We look forward to working with you!