

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

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

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

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):

Years

(If 1, 2, or 3 complete if appropriate)

How old is the primary care giver?

ITEMS 2-5 MUST BE COMPLETED ON EACH FORM

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

7a. Person's Social Security Number

7b. Person's Medicaid Number

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

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

For information purposes only. Not an application for services.

11. Disabilities: (Mark all that apply)

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

- | | |
|---|---|
| 7 <input type="radio"/> Parent Training | 11 <input type="radio"/> Substance Abuse Services |
| 8 <input type="radio"/> Advocacy | 12 <input type="radio"/> Rent Subsidy |
| 9 <input type="radio"/> Sexuality Counseling | |
| 10 <input type="radio"/> Future Planning (e.g., guardianship, trusts) | |

Respite

- | | |
|--|--|
| 13 <input type="radio"/> Adult/Child care (during working hours, after school) | |
| 14 <input type="radio"/> Respite (Day/Evening) | 15 <input type="radio"/> Respite (Overnight) |

Assistive Technology

- | | |
|---|---|
| 16 <input type="radio"/> Adaptive Equipment | 17 <input type="radio"/> 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)

12. Preferred Language: (Mark all that apply)

- | Spoken | Nonverbal | Understood |
|---------------------------------|--|---------------------------------|
| 1 <input type="radio"/> English | 1 <input type="radio"/> Sign | 1 <input type="radio"/> English |
| 2 <input type="radio"/> Spanish | 2 <input type="radio"/> Other Symbolic | 2 <input type="radio"/> Spanish |
| 97 <input type="radio"/> None | 97 <input type="radio"/> None | 97 <input type="radio"/> None |
| 98 <input type="radio"/> Other | 98 <input type="radio"/> Other | 98 <input type="radio"/> Other |
| <input type="text"/> | <input type="text"/> | <input type="text"/> |

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

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 <input type="radio"/> In-home residential habilitation services | 4 <input type="radio"/> Service Coordination |
| 2 <input type="radio"/> Home Care/Home Maker | 5 <input type="radio"/> Transportation |
| 3 <input type="radio"/> Recreation | 6 <input type="radio"/> Behavior Management |

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