The Way Forward!

EIHAB HUMAN SERVICES

EIHAB provides a comprehensive array of person centered services to support individuals with intellectual and developmental disabilities throughout New York City and Long Island. Each program provides opportunities for increased self sufficiency, socialization, and community inclusion, helping individuals to reach their goals and lead bright, fulfilling lives.

Day Habilitation

Our Day Habilitation Without Walls Programs provide individuals with the necessary skills to thrive in the community. Located in Brooklyn, Queens, and Long Island, our five Day Hab programs are tailored to encourage employment opportunities for individuals, equipping participants with pre-vocational training and essential workplace skills to forge a successful path. In addition, individuals have the opportunity to volunteer at local food pantries and other sites, learning the importance of giving back to the community. Day Hab program participants also take part in recreational activities, community outings, physical fitness activities, and more. EIHAB provides safe, reliable transportation to and from each Day Hab program.

Residential Services

EIHAB operates 15 well appointed residences across Brooklyn and Queens. Our high quality residential services provide 24 hour personalized care to ensure a safe, nurturing environment for every resident. Through person centered planning, individuals develop important daily living skills, such as self care and money management, as they achieve greater independence.

Our outstanding team of Direct Support Professionals (DSPs), nurses, behavior specialists, speech therapists, and physical/occupational therapists provide around the clock support and supervision to help individuals excel. DSPs accompany residents to in person and virtual medical appointments, offering additional guidance and advocacy. Daily medication monitoring helps to keep individuals on track with their health regimens.

Community Habilitation

Our Community Habilitation Program helps individuals retain and enhance their self-sufficiency and daily living skills. The program is currently offered in Brooklyn, Queens, Nassau, and Suffolk County. Activities are structured to coincide with the life plan of EIHAB's individuals, who work on particular goals and value outcomes in the areas of socialization, self-care, travel safety, communication, money management, and more. Services are provided in the individuals' homes and also within the community.

Respite

Respite care is provided to families and caregivers of individuals with intellectual and developmental disabilities in Brooklyn and Queens who are in need of a short-term break to run errands or to tend to other personal matters. Respite services can be provided by a family member, friend, or skilled care provider – either at home, after Day Hab, or in the community. Services are available during daytime or evening hours on weekdays and weekends and typically comprise one to two hours. Activities range from arts and crafts to community walks.

For all questions regarding Application Process or to check on the status, please contact EIHAB Outreach & Central Intake Division at intake.admissions@eihab.org or call 718 276 6101 ext. 403. You can also reach our Intake Coordinator *Sandy Moreira at (347) 443 4134* or email at sandy.moreira@eihab.org.

Thank you for your interest in EIHAB !

Central Intake Guidelines for OPWDD Waiver Services

Below is EIHAB 's Central Intake process for Office for People with Developmental Disabilities (OPWDD) Home and Community Based Services (HCBS) Waiver (see below for applicable services).
Please read these guidelines carefully to understand the process and guidelines to help individuals, families, and Care Coordinators navigate our process.

Please note that a Care Coordinator is required to make a referral for all of these services*

*EIHAB 's Central Intake Department processes referrals Monday through Friday, and is closed on all major holidays. Intake referrals are processed on a daily rotation. Within 24 business hours of receipt of referral, the Intake Specialist processing referral will be in contact with the Care Coordinator who submitted the referral to confirm receipt of referral and request any missing pieces. *After 48 business hours, if you have not received a response, please contact Central Intake by email at intake.admissions@eihab.org or call Sandy Moreira, the Intake Coordinator at (347) 443-4134 to confirm your referral was received**

REFERRAL PROCESS

The following services require a referral through EIHAB 's Central Intake process:

- Day Habilitation (site-based/certified)
- Day Habilitation (non-certified/Without Walls)
- Community Habilitation (all types)
- Respite (all types)
- Residential IRA (supportive/supervised)

**All requests for *Residential Placement* must be submitted by an individual's Care Coordinator to the OPWDD Certified Residential Opportunities (CRO) team. EIHAB cannot consider anyone for residential placement without approval from OPWDD CRO team nor will tours be provided of EIHAB residences unless authorized by the OPWDD CRO team. Any questions regarding the CRO process should be emailed to wny.vacancy.management.group@opwdd.ny.gov.

Qualifications for all applicable HCBS Waiver services with EIHAB

- Individual must be eligible and able to provide Notice of Decision or proof of eligibility with OPWDD
- If new to OPWDD services or transitioning from school to adult services, prior to submitting referral, individual must:
    - Have gone through the OPWDD Front Door process and obtained necessary authorization(s)
    - Have a Care Coordinator
    - *Individual must be HCBS Waiver enrolled **prior to referral.***
        - *Care Coordinators are encouraged to contact OPWDD to confirm individual's enrollment is active- if individual has not had active service in 1+ year, individual may need to apply again- referrals WILL be delayed if individual's Waiver status is not active*

EIHAB HUMAN SERVICES

Application & Required Documents

(Please complete the Intake Application in its ***ENTIRETY*** *(all fields are required for all services, omissions may cause delay in processing).*

We strongly encourage entire referral packet be sent together for tracking purposes. Referrals will not be processed nor will individuals be placed on waiting lists until complete packet is received

The following list of documents (also outlined on the application) must be provided to EIHAB 's Central Intake Department before referrals can be transferred for programmatic review:

EIHAB Intake Application for OPWDD Waiver Services

- The Attached Intake Application Most Recent Life Plan
- HCBS Waiver Notice of Decision (NOD) OR Tabs Inquiry from CHOICES if NOD is not available
- Current Level of Care Eligibility Determination (LCED)
- Front Door Authorization Letter (entire letter)/Entire Service Amendment Form (SAF) completed by the Care Coordinator, with DDRO authorization/ OPWDD Certified Residential Opportunities (CRO)
- Nursing Care Plan(s) (if applicable)
- Behavior Support Plan(s) (if applicable)
- Physical (current within 1 year) and list of all current medications
- Psychosocial and Psychological (within 3 years)
- DDP-2

(Please be advised, more documentation may be requested by program(s) as part of the enrollment process.)

Once all required documents above are received and reviewed, the referral packet will be transferred for programmatic review. At this point in the Intake Process, Care Coordinators will be notified that referral is being transferred and will be provided a program staff contact for status updates after this point

Submission Directions

Compiled packets with all of the required documents can be sent to EIHAB by one of the following methods:

- **Email (MUST be sent in a HIPAA compliant manner):** intake.admissions@eihab.org
- Please note, all Microsoft Word documents, secure emails containing authorization or other information, or One Drive documents should be converted to PDF prior to emailing to Central Intake.
- **Fax (to the attention of Central Intake):** ***(Please contact Central Intake to confirm receipt after 5 business days)*** {##efax##}

For all questions regarding this process or to check on the status of a submitted referral packet, please contact EIHAB Outreach & Central Intake Division at intake.admissions@eihab.org or call (718)276-6101 ext. 403. You can also reach to our Intake Coordinator *Sandy Moreira at (347) 443-4134* **or email or at sandy.moreira@eihab.org.**

Requesting Additional Services from EIHAB

- Individuals already receiving one or more services from EIHAB will be required to go through the Central Intake process again when requesting additional services from EIHAB under the following circumstances (please contact our Central Intake Department if you unsure as to whether these circumstances apply):
    - Current service and new service(s) are provided by different divisions of EIHAB
    - New service(s) require different authorization(s) than current service(s)
- When a Care Coordinator is submitting for additional services as outlined above within **ONE YEAR** of previous intake referral, the Care Coordinator will need to complete a new referral form and provide authorization for new service(s) but do not need to send the additional required documentation **UNLESS** there has been an update to these documents (i.e. a new Life Plan, new physical, etc.). Any referral after 12 months of previous referral will need to send all updated documentation.

To find out more about our services, please visit us online at www.EIHAB.org or on Instagram and Facebook @EIHAB

EIHAB Human Service Provider Application

Please complete this application in its entirety to avoid processing delays

Date of Application: _____ Name of Applicant: _____

DOB: _____Tabs #: _____ Gender: _____ SSN#: ___-___-_____

Applicant Primary Phone Number: ____-____-_____ Secondary: ___-_____-_____

Applicant Address: _____

Applicant Email: _____

Medicaid #: _____Medicare # (if applicable):_____ Primary Language: _____

Do you have private/3rd party insurance? Yes ☐ No ☐ If yes, please provide the following:

Company/Plan Name _____ Insured_____

ID # _____ Group Number _____

Parent/Legal Guardian/Advocate	**Phone Number** (if different than applicant)	**Email Address** (if different than applicant)

CCO (check one): ☐Care Design ☐ACA ☐PHP ☐ Tr-County Care Design ☐PCS ☐ Prime Care

Care Coordinator (CC) Name: _____ Phone #:____-____-_____ CC Email: _____

CC Mailing Address: _____

CC Supervisor Name: _____ Phone #:____-____-_____

Supervisor Email: _____

Service(s) Requested: (Please check all that apply): *Please be aware that some services may be experiencing waiting periods due to COVID-19 or other factors. Please ask your Intake Coordinator for more information*

Site-Based Day Habilitation Programs:	**Residential**
☐ Day Habilitation (2 sites) Queens	☐ Residential Supervised IRA - Queens
☐ Day Habilitation (1 sites) Brooklyn	☐ Residential Supervised IRA – Brooklyn
☐ Day Habilitation WOW (3 sites) – Suffolk, Nassau, Brooklyn	☐ Residential Supportive IRA – Queens
Respite Programs:	**Community Habilitation:**
☐ In-Home Respite – Brooklyn and Queens	☐ Community – Brooklyn
☐ After School Respite – Brooklyn	☐ Community – Queens
☐ Saturday Respite - Brooklyn	☐ Community – Suffolk
	☐ Community – Nassau

##For Community Habilitation, are you starting service with a requested staff member? ☐ No ☐ Yes

If so, please attach the persons resume and fill in below:

Applicants Full Name_____ **Contact Phone Number:**_____

***Please note: All requests and inquiries for Residential Habilitation must follow the OPWDD Certified Residential Opportunities (CRO) Process*- for more information, please call OPWDD at (800) 487-6310.**

Does applicant need a referral for Physical Therapy (PT), Speech Therapy (ST) or Mental Health Counseling (MH)?
Please check all that apply: ☐ **None** ☐ **PT** ☐ **ST** ☐ **MH** (If service(s) are checked, Care Coordinator will be provided the Article 16 intake packet to complete. This will then be provided to EIHAB's Management Team who will do all follow up, NOT Central Intake Staff.)

Is applicant enrolled in HCBS Waiver: ☐ Y ☐ N ☐ Pending- Date of submission to DDRO: _____

If yes, has Care Coordinator confirmed that Waiver status is *ACTIVE?* ☐ Y ☐ N

List all current OPWDD (i.e. Respite, Self-Direction, Day Hab, etc.) **and non-OPWDD** (Care Coordination, CASA, DOH, OMH, etc.) **services being received:**

Service	Provider Name	Provider Contact Name	Provider Contact Phone #

Reason for referral: (Required for all services- describe situation, use additional paper if needed)

_____
_____
_____
_____
_____
_____
_____
_____
_____

Developmental Disabilities

Intellectual Disability: (Select One) ☐Mild ☐Moderate ☐Severe ☐Profound ☐Undetermined
☐Cerebral Palsy ☐Epilepsy/Seizure Disorder ☐Autism ☐Neurological Impairment
Does this individual have a Psychiatric Diagnosis? Yes ☐ No ☐ If yes, please list:_____
Verbal ☐ Non-verbal ☐ Communication methods (if any): _____
Ambulatory ☐ Non-Ambulatory ☐ Explain any needed mobility supports:_____
_____
Please list all medical diagnoses: _____
_____

Does applicant have any known allergies? Y ☐ N ☐ If yes, please list allergy, typical reaction, treatment:

_____
_____

Levels of Care/Supervision

Describe level of care/supervision required AT HOME: _____

Describe level of care/supervision required AT DAY PROGRAM: _____

Describe level of care/supervision required IN THE COMMUNITY: _____

Describe level of care/supervision required OTHER (please specify in description): _____

_____

Available Transportation (please check all that apply)

Own Car ☐ Family Provided ☐ Medicaid Transportation ☐Paratransit ☐Other: _____

Personal Care	**Independent**	**Needs Help**	**Dependent**
Toileting			
Urination	☐	☐	☐
Bowels	☐	☐	☐
Transfers while toileting	☐	☐	☐
Wash hands	☐	☐	☐
Dressing	☐	☐	☐
Undressing	☐	☐	☐
Tub/Shower	☐	☐	☐
Wash body	☐	☐	☐
Wash hair	☐	☐	☐
Comb hair	☐	☐	☐
Brush teeth	☐	☐	☐
Menstruation Care	☐	☐	☐
Mealtime			
Eats	☐	☐	☐
Drinks	☐	☐	☐
Cuts food	☐	☐	☐
Cleans self	☐	☐	☐
Medication Administration	☐	☐	☐

Wears briefs/diapers: Yes ☐ No ☐

Adaptive equipment for toileting: Yes ☐ No ☐

G-Tube Fed: Yes ☐ No ☐

Adaptive equipment for feeding: Yes ☐ No ☐

Are there any dietary orders, special diet, supports needed during feeding, please list: _____

_____

Behavior *(*If the individual has any current behavior plans, they will be required with this application.)*

Are there any behavior concerns with this individual? Yes ☐ No ☐ if yes, please continue. If no, please skip to "".**

Does this individual have a behavior management program or plan at: Home ☐ School ☐ Day Program ☐ Other ☐

Please check all behaviors that are addressed in their plan: Wanders/elopes ☐ Destruction of property ☐ Physical aggression towards staff ☐ Physical aggression towards peers ☐ Sexually inappropriate behavior ☐ Non-compliance ☐ Screams/swears/verbal aggression ☐ Self-injurious behavior ☐ Biting ☐ Urination/defecation ☐

What strategies have been attempted to address these behaviors? _____

_____

Are there strategies/techniques that have been especially effective? Please describe. _____

_____

Please describe any other important information or history regarding behaviors: _____

_____

**Is this individual sexually consenting? Y☐ N ☐ has not been evaluated ☐ unsure ☐

Is this person under Psychiatric Care? Y ☐ N ☐ If yes, name of provider(s): _____

Medications prescribed to treat behaviors: _____

_____

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- **EIHAB Intake Application for OPWDD Waiver Services**
- **Most Recent Life Plan**
- **HCBS Waiver Notice of Decision** (NOD) OR **Tabs Inquiry** from CHOICES if NOD is not available.
- **Current Level of Care Eligibility Determination** (LCED)
- **Front Door Authorization Letter** (entire letter)/Entire **Service Amendment Form** (SAF) completed by the Care Coordinator, with DDRO authorization OR **OPWDD Certified Residential Opportunities** (CRO)**,** with DDRO authorization.
- **Nursing Care Plans** for all sites that individual receives services.
- **Behavior Support Plan(s)** (if applicable) for all sites that individual receives services.
- **Physical (current within 1 year) and list of all current medications**
- **Psychosocial and Psychological** (within 3 years)
- **Current DDP2**

Person Completing Referral *(typed or hand-written)***:**_____

Title of Person Completing Referral: _____ **Date:** _____

For Central Intake Administrative Use Only

Required Document	Date Received		Service Authorization		
Life Plan			**Desired Service**	**DDRO Authorized Units**	**Converted Units**
Waiver NOD/Tabs Inquiry					
Psychological & Psychosocial					
DDP2					
Current LCED					
FD Auth. Letter/SAF					
BSP/NCP			☐ **Eligible – Present to Admission Committee : Date**_____		
Physical/Medication List			☐ **Pending Verification of Eligibility:**_____		

☐ **Person Centered Screening recommended** ☐ **Person Centered Screening not recommended**		Scheduled Screening Date _____
☐ **Person Centered Assessment Visit recommended** ☐ **Person Centered Assessment Visit not recommended**		Assessment Visit(s) Date _____
IDT Team Determination: ☐ **EIHAB not Accepted** ☐ **EIHAB Accepted – Services:** _____		