



NY CONNECTS NIAGARA COUNTY

Choices for Long Term Care

Agency Information

Please provide the following information regarding your agency. Information regarding specific programs should be indicated on pages 2 through 6. If your agency only provides one type of program or service, please skip page 2 and complete pages 3 through 6 only.

1. Agency Name: _____

2. Popular Names, Acronyms: _____
3. Former Names: _____
4. Street Address: _____

5. Mailing Address (if different): _____

6. Site Addresses: _____

7. General Phone Number(s): _____
8. TDD/TTY Number: _____
9. General Fax Number: _____
10. Website Address: _____
11. General Email Address: _____
12. Days & Hours of Operation: _____
13. Geographic Area Served: _____

14. Languages In Which Services Are Provided: _____

15. Contact Name & Title: _____

Program Information

Please make copies of pages 2 through 6 and complete one set for each program offered through your agency. If your agency only offers one program, please skip this page and complete pages 3 through 6.

1. **Program Name:** _____

2. **Popular Names, Acronyms:** _____
3. **Former Names:** _____
4. **Street Address (if different from agency address):** _____

5. **Mailing Address (if different from agency address):** _____

6. **Other Site Addresses:** _____

7. **Program Phone Number(s):** _____
8. **Program Fax Number:** _____
9. **Program Email Address:** _____
10. **Days & Hours of Operation:** _____
11. **Program Contact Name & Title:** _____

Please attach any available program brochure and/or additional information for our file.

1. **Services Provided (please check):** Please indicate if services are provided in an individual's home (home-delivered meals, personal care, etc.), in the community (congregate dining, respite care, etc.) or both. For example, if physical therapy services are provided in a person's home as well as at your facility, please check both boxes.

	<i>In-Home</i>	<i>Community-Based</i>
Activities of Daily Living Assessment (PRIs)	_____	_____
Adult Day Care-Medical	_____	_____
Adult Day Care-Social	_____	_____
Advocacy Programs	_____	_____
Assistive Technology Equipment	_____	_____
Caregiver Training	_____	_____
Case/Care Management	_____	_____
Centers for Independent Living	_____	_____
Child Specific Services:		
Child Care Provider Referrals	_____	_____
Early Intervention for Children with Disabilities or Delays	_____	_____
Special Education Assessment	_____	_____
Companionship Programs	_____	_____
Congregate Meals/Nutrition Sites	_____	_____
Developmentally Disabled Services:		
Family Support Services:		
Advocacy Programs	_____	_____
Counseling, Training and Support	_____	_____
Day Habilitation Programs	_____	_____
Medicaid Service Coordination	_____	_____
Prevocational Services	_____	_____
Residential Habilitation	_____	_____
Residential Services		
Community Residences	_____	_____
Emergency Shelter	_____	_____
Family Care Homes	_____	_____
Individualized Residential Alternatives	_____	_____
Intermediate Care Facilities	_____	_____
Non-Certified Housing Options	_____	_____
Respite Care	_____	_____
Supported Employment/Vocational Services:	_____	_____
Food Pantries	_____	_____
Food Stamps	_____	_____
Friendly Visiting	_____	_____
Health Care Services	_____	_____
Home Delivered Meals	_____	_____
Home Health Care	_____	_____

	<i>In-Home</i>	<i>Community-Based</i>
Home Modifications & Repairs:		
Home Barrier Evaluation/Removal	_____	_____
Home Maintenance and Minor Repair Services	_____	_____
Home Rehabilitation Services	_____	_____
Yard Work	_____	_____
Hospice	_____	_____
Household Safety Education	_____	_____
In Home Attendants for People with Disabilities	_____	_____
Insurance/Benefit Information and Counseling		
Government Subsidized Prescription Drug Benefits	_____	_____
Health Insurance Information and Counseling	_____	_____
Insurance/Benefit Information and Counseling continued:		
Long Term Care Insurance Information and Counseling	_____	_____
Managed Health Care Information	_____	_____
Medicare Information and Counseling	_____	_____
Medicaid (general information)	_____	_____
Prescription Drug Patient Assistance Programs	_____	_____
Veteran Benefits Assistance	_____	_____
Welfare Rights Assistance	_____	_____
Interpreter/Translator Services	_____	_____
Legal Assistance	_____	_____
Mental Health Services	_____	_____
Nutrition Assessment Services	_____	_____
Nutrition Education	_____	_____
Outreach Programs	_____	_____
Personal Care	_____	_____
Personal Emergency Response Systems	_____	_____
Personal Finances/Budget Counseling	_____	_____
Private Duty Nursing	_____	_____
Property Tax Exemption Information	_____	_____
Protective Services	_____	_____
Rehabilitation Facilities (Inpatient)	_____	_____
Respite Care	_____	_____
Senior Centers	_____	_____
Soup Kitchens	_____	_____
Substance Abuse	_____	_____
Support Groups & Counseling:		
Aging/Older Adult Support Groups	_____	_____
Caregiver/Care Receiver Support Groups	_____	_____
Caregiver Counseling	_____	_____
Disability Related Support Groups	_____	_____
Specialized Counseling Services	_____	_____

	<i>In-Home</i>	<i>Community-Based</i>
Telephone Reassurance	_____	_____
Therapy & Rehabilitation (In Home/Outpatient)	_____	_____
Transportation:		
Automobile/Van Adaptations	_____	_____
Disability Related Transportation	_____	_____
Escort Programs	_____	_____
Medical Transportation	_____	_____
Senior Ride Programs	_____	_____
Utility Payment Assistance	_____	_____
Vocational Rehabilitation	_____	_____
Weatherization Programs	_____	_____
Wellness Program	_____	_____
WIC	_____	_____

Residential Services

Adult Care Homes	_____
Assisted Living Facilities	_____
Congregate Living Facilities	_____
Hospice	_____
Low Income/Subsidized Rental Housing	_____
Non-Subsidized Housing	_____
Skilled Nursing Facilities	_____

Other services provided (please specify): _____

2. **Descriptions of program/service offered:** _____

3. **Eligibility Requirements:** _____

4. **Documentation Required For Service:** _____

5. **Public Transportation:**
Bus Route: _____ Proximity: _____ Para-Transit: _____ Proximity: _____
Metro-Link: _____ Proximity: _____ Other: _____

6. **Application Process:** _____

7. **Cost of Service (please check):**
Fee for service: _____ Free service: _____ Other (please specify): _____

8. **Methods of Payment Accepted (please check):**
Medicare: _____ Medicaid: _____ Insurances: _____
Cash: _____ Check: _____ Credit Card: _____
Money Order: _____ SSI/SSD: _____ Veterans Benefits: _____
Long Term Care Insurance: _____ Other (please specify): _____