Lifestyles for the Disabled, Inc.

930 Willowbrook Road, Bldg 12-G, Staten Island, NY 10314
Phone: 718-983-5351 ● Fax: 718-983-5383 ● www.lfdsi.org

Intake Information Sheet

Participants Name: _____ **Date:** _____

Please tell us a little more about your loved one, the more we know the better we can serve him/her.

Medical Alerts (i.e. seizure disorder, dietary restrictions, allergies, diabetic**):**

_____
_____
_____
_____

Medications (list all medications taken**)**:

_____
_____
_____
_____

Communication, Traveling and ADL Skills (verbal, gestures, utilizes technology, independence with personal activities for daily living, travel trained):

_____
_____
_____
_____

Recreation/Leisure Activities (swimming, sports, music, dance, reading etc**):**

_____
_____
_____
_____

Physical/Health Restrictions/Safeguards (ambulation limitations, phobias, precautions, behavioral alerts or triggers, sensory issues):

_____
_____
_____
_____

Information Lifestyles should know about my child:

_____
_____
_____
_____

Lifestyles for the Disabled, Inc.

930 Willowbrook Road, Bldg 12-G, Staten Island, NY 10314
Phone: 718-983-5351 ● Fax: 718-983-5564 ● www.lfdsi.org

In order to begin the intake process for Lifestyles for the Disabled Programs; the following documents must be submitted……

- Lifestyles for the Disabled Participant Interest Sheet
- Medicaid waiver application
- Document of Choice form
- MSC Application/Confirmation
- Updated Annual Physical Examination Report (Medical)
- Annual PPD (Tuberculosis Test) Report or Statement from a Medical Doctor (Negative Chest X-Ray, Free of active Tuberculosis) – **Within the current year.**
- Current Level of Care
- Legible Photocopy of Medicaid Card
- Legible Photocopy of Social Security Card
- Current Medication Documents and Other Relevant Medical/Medication Information
- Most recent Psychological Evaluation Report
- Most recent Psychosocial Evaluation Report
- Most recent approved and consented Behavior Intervention Program (BIP) (if applicable)
- Most Recent Psychiatric, Speech, Occupational, Physical Therapy Reports (if applicable)
- Most Recent Individualized Service Plan (ISP)
- Addendum to the ISP to include Lifestyles for the Disabled Program
- Current Photograph of interested individual

Please forward all information to:
Annette Raia
Intake Director
930 Willowbrook Road – Building 15L
Staten Island, NY 10314
Phone - 718-983-5351 ext 258
Fax- 718-983-5564 – Email araia@lfdsi.org

Lifestyles for the Disabled, Inc.

930 Willowbrook Road, Bldg 12-G, Staten Island, NY 10314
Phone: 718-983-5351 ● Fax: 718-983-5564 ● www.lfdsi.org

Intake Information Sheet

Lifestyles for the Disabled Participant Interest Sheet

Please complete and return this form to: Annette Raia – araia@lfdsi.org Fax -718-983-5564 or mail to: 930 Willowbrook Road, Building – 15L, Staten Island, NY 10314

Individuals Name:_____

Address: _____

Advocate(s): _____ _____

Emergency Contact: _____

Phone #: (H)_____ **(Cell/Work)**_____

Date of Birth:_____ **Gender:** _____

Social Security #: _____ **Medicaid #:** _____

Tabs#: _____ **Diagnosis:**_____

Email Address:_____

Current School or Day Program:_____

Medical Alerts:_____

Individual has Medicaid Service Coordinator (MSC): Yes ☐ or ☐ No

(MSC) Name:_____

Agency:_____

Phone #:_____ **Cell**_____

Email: _____

PLEASE TURN OVER TO CONTINUE

Lifestyles for the Disabled, Inc.

930 Willowbrook Road, Bldg 12-G, Staten Island, NY 10314
Phone: 718-983-5351 ● Fax: 718-983-5564 ● www.lfdsi.org

Intake Information Sheet

Participants Name: _____ **Date:** _____

Please tell us a little more about the person interested in our program(s); the more we know the better we can serve him/her. Please check all that apply:

Medical Alerts:

- ☐ Major medical issues if yes, please specify _____
- ☐ Medical equipment (i.e. wheelchair, walker, etc) if yes, please specify _____
- ☐ Special medical accommodations (i.e. catheterization, feeding tube, colostomy bag, etc.) if yes, please specify _____
- ☐ Special dietary restrictions (i.e. pureed, ground, chopped) if yes, please specify _____
- ☐ Allergies if yes, please specify _____

Communication:

- ☐ Verbal
- ☐ Non-verbal if yes, please indicate how the individual communicates wants and needs (i.e. gestures, technology, etc.) _____

ADL Skills:

Toileting:

- ☐ Independent
- ☐ Minimal assistance
- ☐ Total support

Feeding:

- ☐ Independent
- ☐ Minimal assistance
- ☐ Total support

Ambulation:

- ☐ Walks independently
- ☐ Walks independently but with difficulty
- ☐ Walks independently with corrective device
- ☐ Requires assistance

Health Restrictions:

☐ No ☐ Yes if yes, please specify _____

Safeguards:

- ☐ Behavioral alerts (i.e. PICA, sensory issues including sounds/noise, etc.)
- ☐ Requires a Behavioral Intervention Plan if yes, please attach a copy of the current BIP

Additional information Lifestyles should know about the individual:

_____

_____

_____

Completed by:_____ Date: _____