

# 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](http://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):

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

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

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

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

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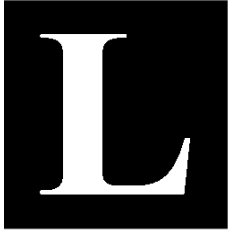
**Information Lifestyles should know about my child:**

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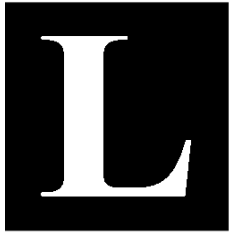
# Lifestyles for the Disabled, Inc.

930 Willowbrook Road, Bldg 12-G, Staten Island, NY 10314  
Phone: 718-983-5351 • Fax: 718-983-5564 • [www.lfdsi.org](http://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](mailto:araia@lfdsi.org)**



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Intake Information Sheet

## Lifestyles for the Disabled Participant Interest Sheet

Please complete and return this form to: Annette Raia – [araia@lfdsi.org](mailto: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

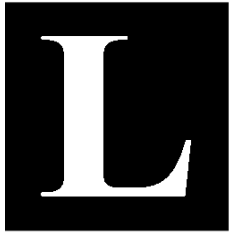
(MSC) Name: \_\_\_\_\_

Agency: \_\_\_\_\_

Phone #: \_\_\_\_\_ Cell \_\_\_\_\_

Email: \_\_\_\_\_

PLEASE TURN OVER TO CONTINUE



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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: \_\_\_\_\_