Lifestyles for the Disabled, Inc.

930 Willowbrook Road, Bldg 12-G, Staten Island, NY 10314
Phone: 718-983-5349 ext 211 • www.lfdsi.org

Lifestyles for the Disabled Participant Interest Sheet

Please complete and return this form to: **Rita Bueti** - Fax -718-983-5383
Or mail to: 930 Willowbrook Road, Building – 12-G, Staten Island, NY 10314

Individuals Name: _____

Address: _____

Advocate(s): _____ _____

Emergency Contact: _____

Phone #'s: (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: _____

Email: _____

PLEASE TURN OVER TO CONTINUE

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Staten Island, New York 10314
Phone: (718) 983-5349 ext 211 Fax: (718) 983-5383

Participant Intake Information Sheet

Participants Name: _____ **Date:** _____

Please tell us a little more about your son/daughter, the more we know the better we can serve them.

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-Fears or Dislikes, precautions, behavioral alerts or triggers, sensory issues):

_____

_____

_____

_____

Please give us any other information Lifestyles should know about your child:

_____

_____

_____

_____

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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: _____