Lifestyles for the Disabled, Inc.

29 Baltic Avenue, Staten Island, NY 10304
Phone: 718-983-5351 ● Fax: 718-983-5383 ● www.lfdsi.org

Lifestyles for the Disabled Participant Interest Sheet

Program applying for:

☐ **Day Habilitation** ☐ **Respite** ☐ **Supplemental Day Habilitation (OPTS)**

☐ **Supportive Employment** ☐ **Community Pre-Vocational**

Name of Applicant: _____

Address: _____ Zip _____

Parent/Guardian(s): _____

Phone #: (Home) _____ (Cell) _____

Email: _____

Emergency Contact Name/Phone: _____

Relationship to the Applicant: _____

Date of Birth: _____ Gender: _____

Social Security #: _____ Medicaid #: _____

TABS ID #: _____ Medicare ID #: _____

Diagnosis: _____

Medical Alerts: _____

Current School/Day Program: _____

Expected Graduation Date (if applicable): _____

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Name of Applicant: _____

Does the Individual have Waiver Eligibility? ☐ Yes ☐ No

Enrolled in Care Coordination? ☐ Yes ☐ No

Care Coordination Organization Agency: _____

Name of Care Manager: _____

Email address: _____

Phone #: _____(Cell) _____

Is the individual enrolled in Self-Direction? ☐ Yes ☐ No

Type of Budget: ☐ All ☐ Residential ☐ Day

If yes: Self-Direction Broker Name: _____

Self-Direction Broker Phone #: _____

Self-Direction Broker Email: _____

Fiscal Intermediary Name: _____

Fiscal Intermediary Agency: _____

Fiscal Intermediary Phone #: _____

Fiscal Intermediary Email: _____

Date of approved budget: _____

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Name of Applicant: _____

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 concern 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/EpiPen? if yes, please specify_____

_____

Medication(s): _____

_____

_____

_____

Safeguards:

☐ Behavioral alerts (i.e. PICA, Sensory issues, phobias, triggers, etc.) if yes, please explain _____

_____

_____

_____

☐ Requires a Behavioral Intervention Plan (if yes, please provide a copy of the current plan)

☐ Requires one-to-one support (if yes, please explain) _____

_____

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Name of Applicant: _____

Ambulation:

□ Walks independently

□ Walks independently but with difficulty

□ Walks independently with corrective device

□ Requires assistance

Communication:

□ Verbal – has conversational language

□ Verbal – one/two words

□ Non-verbal

□ Communication Device

□ Independently gets what is wanted

□ Verbal – speaks in sentences

□ Gestures/Points

□ Sign Language

□ Leads others to get what is wanted

ADL Skills:

Toileting:

□ Independent

□ Minimal assistance

□ Total support

Feeding:

□ Independent

□ Minimal assistance

□ Total support

Showering:

□ Independent

□ Minimal assistance

□ Total support

Changing:

□ Independent

□ Minimal assistance

□ Total support

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Name of Applicant: _____

Recreational/Leisure

Activities applicant enjoys participating in (i.e. swimming, dancing, reading, etc.) _____

_____

_____

_____

Activities applicant avoids/dislikes: _____

_____

_____

_____

Travel trained ☐ Yes ☐ No if yes, please specify (i.e. bus, car service, etc.) _____

_____

_____

Additional Information Lifestyles for the Disabled should know about the applicant: _____

_____

_____

_____

_____

_____

_____

_____

_____

Name of Person Completing this form: _____

Relationship to the Applicant: _____

Date: _____