



**Please submit your Independent Living Program application to:
YAI**

**Attention: Heather Keltai
460 West 34th Street, 11th Floor
New York, NY 10001**

**EMAIL: heather.keltai@yai.org // FAX #: 212-268-1083
For INQUIRIES contact the Heather Keltai: 212-273-6658**

Please include with your application:

- **Psychological Evaluation**
- **Psychosocial Evaluation**
- **PPD Test Results**
- **Current Medical**
- **Any documentation you feel is important for us to have**

Demographic Information:

Application Date: _____

1. Name: _____

2. Date of Birth: _____, _____, _____ Gender: Male Female
month day year

3. Address:

Street

City State Zip code

4. Applicant's Contact Information:

Home Phone#: (_____) _____ - _____

Work Phone#: (_____) _____ - _____

Cell Phone #: (_____) _____ - _____

Email address: _____

5. Language: Check all that apply:

Communication

Spoken English Spanish Other: _____

Understood English Spanish Other: _____

6. Medicaid number: _____ (if known/applicable)

7. Social Security number: _____ - _____ - _____

8. TABS#: _____ (if known)

About You:

Tell us about yourself and why you are applying to the Independent Living Program:

How did you hear about this program?:

I am currently living with...

my family by myself others (who?) _____

In 5 years I want to be living...

where I am living now in a supported apartment in a group home
 in my own apartment other _____

Have you ever lived on your own in a residence/supported apartment?

Yes No

If yes, when and with what agency:

Do you currently participate in any other YAI Programs?

Yes No

If yes, what are the names of the programs?

What do you enjoy to do in your spare time (hobbies, interests etc)? :

What do you do during the day?

- I have a job I go to a day program I go to school
 Nothing right now Other: _____

I travel to and from appointments and places in the city...

- with family members or staff by myself

other _____

I typically take/use _____ when traveling around the city.

- subway taxi bus access-a-ride family car/vehicle walk

other _____

Goals: All the things listed below are topics we talk about or learn about in the Independent Living Program. As you can see we cover a lot of information in 6 months.



In what areas would you like to develop more independence?

Skills/Topics	Very interested	Somewhat interested	Not interested
Using public transportation			
Spending time with friends			
Taking care of my medication			
Making appointments and attending them on my own			
Taking care of my medical needs (for example going to the doctor)			
Asking for help from others when I need it			
Accepting help from others when I need it			
Making plans for my free time to enjoy my hobbies with friends			
Grocery shopping			
Making meals and snacks			
Handling conflicts and arguments with others appropriately			
Paying my bills			
Creating and sticking to a budget			
My understanding of safety in the community and my home			

Dating & relationships			
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Are there other skills/strengths you have that we didn't cover above?

What personal strengths have helped you in achieving independence and your personal goals?

What stops you from reaching your goals of independence?

Additional Contact Information:

9. Additional Services:

Do you have a service coordinator?

- Yes No Unsure

If yes, name of Service Coordinator: _____

Agency Name: _____

Address:

_____ Street

_____ City

_____ State

_____ Zip code

Phone: (____) _____ - _____ ext (____)

Email address: _____

Do you currently see a therapist?

Yes No

If yes, contact name: _____

Address:

_____ Street

_____ City _____ State _____ Zip code

Phone: (____) _____ - _____ ext (____)

Email address: _____

Do you currently participate in any other programs at other agencies?

Yes No

A. If yes, name of contact: _____

Agency Name: _____

Address:

_____ Street

_____ City _____ State _____ Zip code

Phone: (____) _____ - _____ ext (____)

Email address: _____

B. If yes, name of contact: _____

Agency Name: _____

Address:

_____ Street

_____ City _____ State _____ Zip code

Phone: (____) _____ - _____ ext (____)

Email: _____

10. Do you have a legal guardian?

9/29/2017

Yes No Unsure

11. Name of Legal Guardian/Parent/Caregiver(s): _____

Relationship: _____

Address:

_____ Street

_____ City _____ State _____ Zip code

Phone: (____) _____ - _____ Email Address: _____

12. Emergency Contact Person(s):

Name: _____ Relationship: _____

Address:

_____ Street

_____ City _____ State _____ Zip code

Phone: (____) _____ - _____

13. If the first contact person cannot be reached the back up person is:

Name: _____ Relationship: _____

Address:

_____ Street

_____ City _____ State _____ Zip code

Phone: (____) _____ - _____

Medical Information

14. Health Insurance:

Company Name: _____

Policy Number: _____ In Name of: _____

15. Do you take any medications?

Yes No

If yes, please list the condition and all current medications:

Condition	Medication	Dosage Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

19. Do you have a seizure disorder/epilepsy?

Yes No Type of Seizure _____

If yes, how often?

daily weekly monthly 3 months less often

How long do they usually last?

What do you do when a seizure occurs?

20. Do you have any allergies (medications, environmental or food)?

Yes No

If yes, please explain to what:

21. Do you have any dietary needs? (Gluten-free, low calorie, low or no sugar)

Yes No

If yes, please explain:

22. Is there anything else you'd like to tell us?

Information obtained from

Relationship to applicant (self/parent/MSC etc)

Signature

Date