YAI Seeing beyond disability.

Please submit your Independent Living Skills Program application to:
YAI
Attention: LINK
460 West 34th Street, 11th Floor
New York, NY 10001
EMAIL: link@yai.org // FAX #: 212.268.1083
For Inquiries contact the LINK Department: 212.273.6182

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: _____ (month) _____ (day), _____ (year) Gender: ☐ Male ☐ Female ☐ Other (other specify)

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 Skills 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 Skills Program. We cover a lot of information in 12 weeks.

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			

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?

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?

☐ 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