



Independent Living Skills Program (ILSP) Application

Please submit this 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 LINK: 212.273.6182

Please include with your application:

- Psychological Evaluation
- Psychosocial Evaluation
- Any documentation you feel is important for us to have

Demographic Information:

Name: _____

Preferred Name (if applicable): _____

Date of Birth: _____/_____/_____

Gender: __ Male __ Female _____ Other (specify)

Address: _____

Street

City

State

Zip code

Medicaid number: _____ (if known/applicable)

Social Security number: _____ - _____ - _____ (if no Medicaid)

TABS#: _____ (if known)

Applicant's Contact Information:

Primary contact #: (_____) _____ - _____ __ cell __ home __ work

Second contact #: (_____) _____ - _____ __ cell __ home __ work

Email address: _____

Do you have a legal guardian?

Yes No Unsure

Legal Guardian Contact Information (or Parent/Caregiver if no legal guardian):

Name: _____ Relationship: _____

Primary contact #: (_____) _____ - _____ cell home work

Second contact #: (_____) _____ - _____ cell home work

Email Address: _____

Address: _____
Street

_____ City _____ State _____ Zip code _____

Emergency Contact Person:

Name: _____ Relationship: _____

Phone: (_____) _____ - _____; (_____) _____ - _____

Should we contact this person with program updates? Yes No

Second Emergency Contact Person:

Name: _____ Relationship: _____

Phone: (_____) _____ - _____; (_____) _____ - _____

Should we contact this person with program updates? Yes No

Languages (Check all that apply):

Communication
Spoken English Spanish Other: _____

Understood English Spanish

Other: _____

Services Information

Do you have Self Direction?

Yes No Unsure

Do you have a care manager?

Yes No Unsure

If yes, name of Care Manager: _____

Agency Name: _____

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

Email address: _____

What borough(s) are you interested in attending group in?

(Check all that apply)

Manhattan Brooklyn Queens Bronx

Medical Information

Do you have a seizure disorder/epilepsy?

Yes No (move on to next question)

If yes, type of Seizure_____

How often?

daily weekly monthly 3 months less often

How long do the seizures usually last?

What do you do when a seizure occurs?

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

Yes No

If yes, please explain to what:

Do you have any dietary needs? Yes No

(Gluten-free, low calorie, low or no sugar, please explain)

Please describe any other medical/health conditions not listed above:

Please note that staff are not able to administer medication. You must be able to self-administer medication if needed during group hours.

Thank you for completing this application. Once the application is received, we will be contacting you to discuss the next steps in the process.

Preferred Contact Person:

Name:_____

Phone #:_____

Email:_____