YAI Seeing beyond disability.

Independent Living Skills Program (ILSP) Application

Please submit this application to:
YAI
Attention: LINK
220 East 42nd Street, 8th Floor
New York, NY 10017
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.

Date of application: _____

Preferred Contact Person:

Name:_____

Phone #:_____

Email:_____