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.

Preferred Contact Person:

Name:____

Phone #:______________________________________

Email:____