JEWEL HUMAN SERVICES INC

MAIN OFFICE
121-10 153RD STREET
JAMAICA, NY. 11434

DAY HABILITATION PROGRAM
548 LINDEN BLVD.
BROOKLYN, N.Y. 11203

DAY HABILITATION INTAKE FORM

LAST NAME: ________________ FIRST NAME: _________________ INTAKE DATE: _____/_____/_____

ADDRESS: ____ TELEPHONE: (_____)__________

DOB: _____/_____/_____ GENDER: MALE o / FEMALE o MARITAL STATUS: Mo So

MOTHERS NAME: _______________________ FATHERS NAME: __________________________

LEGAL GUARDIAN: ______________________ RELATIONSHIP: ____________________________

TYPE OF RESIDENCE: PRIVATE HOME o / RESIDENTIAL FACILITY o: RESIDENTIAL TYPE: ICF o IRA o CR o

LANGUAGE SPOKEN: _____________SECONDARY: ______________o VERBAL oNON VERBAL oSIGN LANGUAGE

EYE COLOR: ______ HAIR COLOR: ______ HEIGHT: ______ WEIGHT: ______

ETHNICITY/RACE:
—WHITE —HISPANIC —BLACK
—AMERICAN INDIAN/ALASKAN —ASIAN OR PACIFIC ISLANDER

ELIGIBILITY INFORMATION:
PRIMARY DIAGNOSIS: ________________________ ICD CODE: ______

SECONDARY: _______________________________ ICD CODE: ______

DISABILITIES: INDICATE "1" FOR PRIMARY (MARK ONLY ONE) AND "2" FOR ALL OTHER DISABILITIES (MARK AS MANY AS APPLY).

—DEVELOPMENTAL DELAY
—INTELLECTUAL DISABILITY
—AUTISM
—CEREBRAL PALSY
—EPILEPSY/SEIZURE DISORDER
—LEARNING DISABILITY
—OTHER NEUROLOGICAL
—TOXIC SUBSTANCE EXPOSURE IMPAIRMENT
—PSYCHIATRIC DISABILITY
—CHRONIC PHYSICAL/ MEDICAL CONDITION
—SENSORY IMPAIRMENT
—UNDETERMINED
—OTHER (SPECIFY):_________
—TRAUMATIC BRAIN INJURY (TBI)
— FETAL ALCOHOL SYNDROME
__ NARCOLEPSY
__ NEUROFIBROMATOSIS
—PEDIATRIC AIDS
—SPINA BIFIDA
—TOURETTE SYNDROME
__ PRADER-WLLI SYNDROME (PWS)

SS#: □□□□□□□□□ TABS ID: □□□□□□ Medicaid: □□□□□□□□□ Medicare: □□□□□□□□□□□

CONTACT PERSON:

NAME: ______________________________RELATIONSHIP TO CONSUMER: ________________________

ADDRESS: (if different than consumers) ____

____

PHONE#:_______________________ LANGUAGE OF CONTACT: ____________________________________

EMERGENCY CONTACT: PHONE#: ______________________________

NAME: ______________________________

RELATIONSHIP: ______________________

REFERRAL INFORMATION:
(MSC **o**, WAIVERo, SOCIAL WORKERo, SCHOOL **o**, SELF **o**, FRIEND **o**, OTHER **o** __________).

REFERRAL SOURCE: ______________________________
CONTACT PERSON: ______________________________
ADDRESS: ______________________________
PHONE#: ______________________________

PSYCHIATRIC: YES ☐ NO ☐

IF YES, PSYCHIATRIST: ______________________________ TELEPHONE: (_____)__________
ADDRESS: ______________________________ FACSIMILE: (_____)__________
____

MEDICATION: ______________________________

____

BEHAVIORAL ISSUES: o NO o YES, LIST ANY INAPPROPRIATE BEHAVIORS EXHIBITED BY THE CONSUMER AT HOME, PROGRAM AND DURIN OUTDOOR ACTIVITIES (OR DESCRIBED BY THE COLLATERAL), INCLUDE SEVERITY AND FREQUENCY:

____

____

____

MEDICAL INFORMATION:

PRIMARY PHYSICIAN: ______________________________ ***TELEPHONE: (   )*** __________

____

□ MEDICATIONS: ______________________________
□ SEIZURE DISORDER: ______________________________
□ ALLERGIES/DIET: ______________________________
□ ADVERSE DRUG REACTIONS: ______________________________
□ ANY MEDICAL CONDITION: ______________________________
TUBERCULOSIS TEST: / / □ NEGATIVE □ POSITIVE RADIOLOGICAL EXAM: / /
MOBILITY STATUS: □ AMBULATORY □ NON AMBULATORY □ WHEELCHAIR □ CRUTCHES □ WALKER
HEARING: VISION: OTHER:

STRENGTHS AND NEEDS ASSESSMENT:

ADL FUNCTIONING
FOR EACH AREA IDENTIFY WHETHER THE CONSUMER IS INDEPENDENT, OR REQUIRES VERBAL OR PHYSICAL ASSISTANCE:

TOILETING	IND_______	VERBAL ASS. _______	PHY ASS. _______
SHOWERING	IND_______	VERBAL ASS. _______	PHY ASS. _______
DRESSING	IND_______	VERBAL ASS. _______	PHY ASS. _______

EATING IND_______ VERBAL ASS. ______ PHY ASS. _______

TRAVEL TRAINED IND_______ VERBAL ASS. _______ PHY ASS. _______

COMMENTS:____

____

COGNITIVE FUNCTIONING
DESCRIBE CONSUMERS LEVEL OF COGNITIVE FUNCTIONING. INCLUDE DISABILITIES, WHICH IMPACT ON FUNCTIONING LEVEL, SUCH AS: ACADEMICS, READING, WRITING, MONEY SKILLS, AND ATTENTION SPAN.

____

____

DESCRIBE CONSUMERS EXPRESSIVE AND RECEPTIVE SKILLS. INCLUDE CONSUMERS ABILITY TO COMMUNICATE WITH OTHERS.

____

____

SENSORY MOTOR DEVELOPMENT

HEARING	NORMAL __________	IMPAIRED __________	HEARING AID __________
VISION	NORMAL __________	IMPAIRED __________	GLASSES __________
AMBULATION	AMBULATORY ________	NONAMB ________	ADA EQUP _________

COMMENTS:____

____

FINE MOTOR SKILLS: ☐ INTACT ☐ IMPAIRED

GROSS MOTOR SKILLS: ☐ INTACT ☐ IMPAIRED

ADAPTIVE EQUIPMENT: ☐ NO ☐ YES, LIST:

____

____

SOCIAL/EMOTIONAL
DESCRIBE CONSUMERS SELF-IMAGE AND RELATIONSHIP WITH OTHERS:

____

____

DESCRIPTION OF CONSUMER:

____

____

INTAKE PERSONNEL: ___________________________________ Date:_______________

Jewel Human Services, Inc.

Celebrating the Spirit of Life
121-10 153rd Street
Jamaica New York 11434
Telephone Number (347) 741 8495
Fax Number: (347) 494 4150

Consent Form
Information release

We understand and acknowledge that information on the application and current contracts are absolutely necessary for the proper and competent delivery of services by Jewel Human Services, Inc. We warrant that we have fully disclosed all the pertinent facts about _________________________________. If any changes occur, we shall notify a representative of Jewel Human Services, Inc. as soon as possible.

We understand that Jewel Human Services, Inc. in performing its services is acting in full reliance upon the accuracy of the information given by us. We give our permission for Jewel Human Services, Inc. to have access to the information. Upon the decision of a representative of Jewel Human Services, Inc. we give our permission for Jewel Human Services Inc. to release information on _________________________________ to any other individuals needing access to this information for necessary services.

Participant Signature: __________________________________ Date: ______________

Primary Caregiver Signature: ____________________________ Date: _______________

Witness Signature: ____________________________________ Date: _______________