Jewel Human Services, Inc.

867 West Merrick Boulevard, Valley Stream, N.Y. 11580
Phone: 347-741-8495 / Fax: 516-285-0686

INTAKE and ASSESSMENT

DATE:_____

NAME:_____DOB:_____Gender: Male___Female_____
Home Address: _____

Home Phone: _____ **Cell Phone:_____**

Work Phone: _____ **Email address:_____**

Medicaid: No__Yes__if yes, Medicaid#:_____Social Security#:_____
Other Heath Insurance _____

Type of Residence: Family____Agency____If agency, name and contact information of sponsoring agency_____

Name of Primary Caregiver:_____Relationship:_____
Address (If different than above):_____

Primary Diagnosis:_____ **Secondary Diagnosis:_____**
Psychiatric Diagnosis_____

Is the applicant receiving Medicaid Service Coordination or Case Management? : No_Yes__
If yes, please provide the following information:
Agency:_____Name of MSC or Caseworker: _____
Address:_____Phone #:_____Email _____

Which services are you interested in at Jewel Human Services?
(Please check all that apply)

Prevoc	**Day Habilitation**	**Community Habilitation**
After-school Respite	**Respite**	**Fiscal Intermediary**
SEMP	**Individualized Support Services**	**Other (please specify)**
School Holiday Respite	**Broker Services**	

MEDICAL/EMERGENCY INFORMATION:

Does the individual currently or have a history of any pertinent medical conditions (i.e. – seizure disorder, hypertension, diabetes, etc.)? If so, please provide detailed information:

_____

_____

Does the individual have any special health care needs that we should be aware of (IE – known allergies to foods/drugs, special diet orders, etc.)?: No_____Yes_____If yes, please provide detailed information: _____

_____

Does the individual take any medication? No_____Yes_____If yes, please provide us with the following information:

Medication	Dose	Reason	Possible Side Effects

Primary Care Physician:_____**Phone #:**_____
Address:_____
Psychiatrist_____**Phone #:**_____
Address:_____
Neurologist:_____**Phone #:**_____
Address: _____

EMERGENCY CONTACT INFORMATION

Name	Address	Home/ Cell #	Email	Relationship

SCHOOL/PRIOR PROGRAM EXPERIENCE:

Is the individual currently in school or day program?: No_____ Yes_____
If yes: Name of School_____School Address_____
School/Program Phone #:_____Contact Person:_____
Anticipated Date of Graduation:_____

Please list current and past day program affiliations:

Agency:	Address:	Phone #:	Contact Person:	Type of Program (day hab, SEMP, etc.):	Reason for leaving:

Has the individual ever participated in any type of community/volunteer service program(s) in the past? No_____Yes_____
If yes, please describe the types of activities the individual participated in (i.e. – senior center, library, hospital, etc.):_____
What types of activities/tasks does the individual prefer to participate in (i.e. – clerical work, maintenance, independent, computer related, etc.)?_____
_____
Has the individual ever participated in an Employment program? No_____Yes_____
If yes, please provide details about type of employment, agency affiliation and reason for leaving position:_____
_____

BEHAVIORAL INFORMATION:

Does the individual exhibit or have a history of exhibiting any of the following behaviors? (Please check all that apply)

Self-injurious behaviors:	Physical aggression towards others:	Verbal aggression:	PICA/Ritualistic behaviors:
Self-stimulatory behaviors:	Taking things that belong to others:	Sexually assertive behaviors:	Making false statements:
Wandering/elopemen	Talking to strangers:	Echolalia:	Other:

For all areas checked, please describe: _____
_____
_____
_____
_____
_____
What should we do when the individual is upset, frustrated, etc., in an effort to help them regain control and/or feel better (i.e. talk with them, give personal space, listen to music, etc.)?_____
_____

What types of things reinforce/motivate the individual? (i.e. verbal praise, computer time, snack, etc)?

Does the individual currently possess any independent travel skills? No:____Yes____
If yes, please describe (walks from home to local store, is able to cross streets, can take bus or subway to movie theater, etc.):

What level of supervision does the individual require in the community?
Why?

Are there any environmental issues that would be important for us to know (i.e. sensitive to loud noises, doesn't like crowds, fears or phobias, etc.) No_____Yes_____If yes, please explain:

Is there anything else you think would be important for us to know about the individual?_____

Completed By:

Name	**Relationship**	**Signature**	**Date**

Intake Conducted By:

Name	**Title**	**Signature**	**Date**

For internal use:
Summary/Comments (including next steps, follow up, referrals, etc.)

(Enter dates of the assessments)

LOC:	**ISP:**	**Addendum:**	**M/C card:**	**IEP:**
Physical:	**Psychological:**	**Psychosocial:**	**Admissions Packet:**	
Liability form:	**DDP 2:**	**Waiver Packet:**	**NOD**	