

INTAKE APPLICATION

PLEASE CHOOSE ALL THAT APPLY:

- Residential Placement
- Care Coordination
- Community Habilitation
- Respite



Formerly: Women's League Community Residences, Inc.

1556 38th Street • Brooklyn, NY 11218 • (718) 853-0900

A tradition of caring in our homes and yours

Application for Admission

Please attach a copy of a recent psychological, psychosocial, medical evaluation and Individualized Service Plan (ISP). Responsibility for obtaining and submitting these reports rests with the applicant.

Please print your answers to all the following questions. If a question does not apply to you, please write N/A (not applicable).

1. Full Name of Applicant _____
2. Applicant's Present Address _____

3. Phone #: _____
4. Email Address: _____
5. Gender: _____ Male _____ Female
6. Date of Birth: _____
7. Social Security #: _____
8. Medicaid #: _____
9. Medicare #: _____
10. TABS #: _____
11. Place of Birth: _____
12. Diagnosis: _____

13. Is the applicant a U.S. Citizen? Yes _____ No _____
14. If applying for residential placement, does applicant currently receive a monthly SSI check? Yes _____ No _____
15. Name, Address & Telephone # of person filling out this application:

- Relationship to Applicant: _____
16. Referred by: _____ Phone #: _____

If not, where does applicant receive medical attention?

Has the applicant had any unusual illness or accident? Yes No

If yes, when? _____

Explain _____

23. Please list any medical conditions the applicant has:

24. Is applicant receiving any medication? Yes No

If yes, please list medications, and for which condition:

25. Does the applicant have any allergies? Yes No

If yes, please list allergies and medication (if any) addressing this issue: _____

26. Is the applicant able to ambulate independently? Yes No

If not, please describe any supports needed: _____

27. Is the applicant toilet trained? Yes No

If yes, completely or partially? Completely Partially

If partially, explain: _____

28. Please describe any behavior issues: _____

FAMILY INFORMATION

Father/Guardian's Name: _____

Address: _____

Father/Guardian's contact#: Cell: _____ Work: _____

Occupation: _____

Mother/Guardian's Name: _____

Address: _____

Mother/Guardian's phone #: Cell: _____ Work: _____

Occupation: _____

Marital status of parents: _____

Emergency Contacts:

	<u>Name</u>	<u>Relationship</u>	<u>Phone #</u>
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Signature of Applicant or Guardian

Date

Accompanying Documentation Checklist:

- Psychological Evaluation
- Psychosocial Evaluation
- Medical Evaluation
- Most recent ISP (if available)
- Documentation of Disability before age 22 (if available)

Please send completed application and reports to:

Tsirel Winograd, Intake Coordinator
Makor Disability Services
1556 38th Street
Brooklyn, NY 11218
Fax: 347-390-8225
twinograd@makords.org