



Action Toward Independence, Inc.

Consumer Intake Intake Date: _____

Last Name: _____ MI _____ First Name: _____

Gender: _____ Male _____ Female DOB _____ - _____ - _____

Home Phone: _____ Cell Phone: _____

Other: _____

I give Action Toward Independence permission to leave a detailed message on my voice mail/answering machine.

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Mailing address: _____ Same as physical address
if different: _____

E-mail address: _____

caregiver or emergency contact:: _____

Relationship: _____ Phone number: _____

Are you a veteran? Yes No

Ethnicity: _____ Hispanic/Latino _____ Other _____ I prefer not to disclose

Race (choose one or more):

- _____ American Indian or Alaskan Native
- _____ Asian
- _____ Black or African American
- _____ Native Hawaiian or Other Pacific Islander
- _____ White
- _____ Other / I prefer not to disclose

Marital Status

- Single
- Divorced
- unknown
- Married
- Widowed
- I prefer not to disclose

Housing Status

- Assisted Living
- Homeless
- Dependent Living with family or friends
- Other _____
- Independent
- Institution

If you rent... do you receive assistance? (such as Section 8?) yes no

Employment Status:

- Full time _____ Hours worked a week
- Part time _____ Hours worked a week
- Looking for a job
- Unemployed, not seeking work
- Student or in training program _____
- Retired
- Segregated work or day program
- Other program not listed above: _____
- Decline to Answer/ Unknown

Last School Completed

- Pre-K
- K-8
- Some High School
- Completed High School
- Some College
- Business/Trade/Vocational School
- 2 yr. Undergrad Degree
- 4 Yr. Undergrad Degree
- Post Graduate Degree
- Unknown / Not yet enrolled

Do you need to receive information in an alternative format?

- No
- yes if so, what method? _____

Are you registered to vote? Yes No If no, would you like to register ? Yes No

Do you feel safe? Yes No

Primary Disability: _____ Age of onset of disability: _____

Date of onset of Disability (if not known, please estimate year) ___/___/___

Please check all that apply:

COGNITIVE

- Intellectual Disability
- Traumatic & Other Brain Injuries
- Learning Disability
- Autism
- Other Cognitive Disabilities

MENTAL/EMOTIONAL

- Mental Illness
- Emotional/Behavioral disabilities
- Substance Abuse
- Other mental illnesses

PHYSICAL

- Spinal Cord Injury
- Neuromuscular
- Orthopedic
- Cerebral Palsy
- Spina Bifida
- Other Congenital Birth Anomaly
- Epilepsy
- Muscular Dystrophy
- Amputation
- Back Injury
- HIV/AIDS
- Environmental/other related illnesses
- Other Physical Disabilities

SENSORY

- Blindness
- Low Vision
- Deafness
- Hard of hearing
- Deaf/Blind
- Other sensory disabilities

Notes:

SERVICES and GOAL CATEGORIES

Date: _____

- A. **Self – Advocacy/Self Empowerment** - Assistance in improving your ability to represent yourself with public and/or private entities or ability to make key decisions involving yourself.

- B. **Communication** – Assistance in improving your ability to communicate with others

- C. **Mobility /Transportation** - Assistance in improving your ability to move or transport in your life-space, environment or community

- D. **Community Services** – Assistance in changing living situation such as obtaining or modifying an apartment or house.

- E. **Educational** – Assistance in improving your basic knowledge or increase your ability to perform certain skills

- F. **Vocational** – Assistance with support in obtaining, maintaining or advancing in employment.

- G. **Self-Care** - Assistance with improving/maintaining activities of daily living such as personal grooming and cleaning, toileting, meal preparation, shopping, eating, etc.

- H. **Information Access/Technology** – Assistance in obtaining and/or using a computer or other assistive technology, devices or equipment.

- I. **Personal Resource** - Assistance in learning to establish and maintain a personal/family budget, managing a checkbook, and/or obtaining knowledge of resources related to income, housing, food, medical and/or other benefits.

Category:

ILP Goal(s): _____

Support from ATI: _____

ILP Goal(s): _____

Support from ATI: _____

ILP Goal(s): _____

Support from ATI: _____

By signing this document, I acknowledge that I have read and understand Action Toward Independence, Inc.'s Privacy Practice and Consumer Rights. I also understand that if I have any further questions or concerns regarding this notice or any other policies and procedures at Action Toward Independence, Inc., I will contact the staff member who is working with me at:

(Orange County Office)
Action Toward Independence, Inc.
P.O. Box 359
Middletown, NY 10940
(845) 343-4284 V & TTY

(Sullivan County Office)
Action Toward Independence, Inc
309 East Broadway, Suite A
Monticello, NY 12701
(845) 794-4228 V & TTY

This acknowledgment will be placed in your Consumer Record that is maintained at Action Toward Independence, Inc.

Consumer Signature

Date

Individual's Name (Please Print)

Representative Signature (& Relationship to Consumer)

Date

Interviewer: _____ **Date:** _____
(Staff Member)

Phone intake completed; all material was read to consumer, then copied and mailed on:

Date: _____