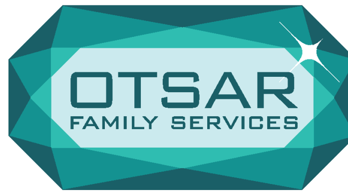

OTSAR DAY HABILITATION PROGRAM
2302 W. 13th St.
Brooklyn, New York 11223
(718) 946-7301

APPLICATION FOR NEW PARTICIPANT

Note: Please type or print all information clearly

1. This application must be completed in its entirety.
2. The following current evaluations must be submitted as part of the application packet: (If not already submitted)

Psychological	-	done within the past 3 years
Psychosocial	-	done within the past 12 months
Medical	-	done within the past 12 months
PPD Test	-	done within the past 12 months
ISP	-	done within the past 6 months

Applicant's Name ____________________ Phone# ____________

Addres ________________________________

City ____________________ State ________ Zip Code__________

Date of Birth ____________ Age _____ Proposed Date of Entry__________

Psychological Evaluation

Date of most recent evaluation ______________ Scale used ______________

Verbal IQ __________ Performance IQ __________ Full Scale IQ __________

Other Personal Information

Medicaid # ______________ VESID Case # ______________

Is applicant a class client? __________ Class Case # ______________

Social Security # ______________ Waiver Eligible ______________

Health Insurance ______________ Policy # ______________

Company Name ______________ Policy in Name of ______________

Program Information

Applicant's current (or most recent) program attended:

Agency: ____________________

Program Name: ____________________

Address: ____________________

City ____________________ State __________ Zip Code__________

Contact Person: ____________________Phone #: ____________________

His/Her position: ____________________Fax #: ____________________

Dates attended: From____________________To ____________________

Reason(s) why you wish transfer from current program into Otsar Day Hab:

____

____

____

If not currently in a program, please explain why not:

____

____

____

____

Previous Programs Attended

Name ____________________

Address ____________________

City ____________________ State ____________________Zip ____________________

Contact Person ____________________Phone # (___)____________________

Position ____________________Dates Attended: From__________ To__________

Name: ____________________

Address: ____

City: ____

Contact Person: _______________________________Phone: ______________________________

Position _______________________________Dates Attended: From __________To _________

Medical Evaluation

Date of most recent medical evaluation: ____

Name of physician: ___________________________Phone # ____________________________

Address: ____

List all current medications (if none, write "none"):

Medication	Dose

Is Applicant self-medicating? Yes _________ No __________

Does Applicant have seizures? If yes please describe:

____

Is Applicant on a special diet? If yes please explain. Please be Specific:

____

____

Does Applicant have any allergies? If yes please list:

____

____

Does Applicant use any adaptive equipment? If so please describe:

____

____

Does applicant have any acting out or violent behaviors? If so please describe:

____

____

Please describe Applicant's strengths:

____

____

Please describe Applicant's weaknesses:

____

____

<u>Self Help Skills</u>:

Does Applicant need assistance in toileting himself? Please elaborate:

____

____

Does Applicant need assistance in feeding himself? If yes please elaborate:

____

____

In what way does Applicant communicate?

____

____

What activities does Applicant enjoy?

____

____

Any additional information you would like us to know?

____

____

____

____

____

____

____

____

____

Emergency Contacts

1. Name ______________________________

   Relationship to applicant ______________________________

   Address ______________________________

   City ____________ State ________ Zip ________

   Phone ( ) ____________ ( ) ____________

2. Name ______________________________

   Relationship to applicant ______________________________

   Address ______________________________

   City ____________ State ________ Zip ________

   Phone: ( ) ____________ State ________ Zip ________

Service Coordinator

Name: ______________________________

Agency: ______________________________

Phone: ( ) ____________ Fax: ( ) ____________

Advocate

Name: ______________________________

Agency: ______________________________

Relationship to applicant: ______________________________

Phone: ( ) ____________ Fax: ( ) ____________

Guardian (Legal)

Name: ______________________________

Agency: ______________________________

Relationship to applicant: ______________________________

Phone: ( ) ____________ Fax: ( ) ____________

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Consent Form

Name ________________________________ Date: ___________________

Trip Approval Form (Mandatory)

I hereby give ____________________________ permission to go on trips and outings with Otsar's Day Habilitation Program. I understand that these outings may include trains/busses/car transportation.

Signature of Parent/Guardian: __________________________________

****

Parent Consent Form (Mandatory)

I hereby grant Otsar consent and permission for any emergency treatment deemed necessary whether medical or surgical for the above participant. I further permit such emergency treatment at the nearest available emergency clinic or hospital (whether City or Private) or Medical Doctor.

Signature of Parent/Guardian: __________________________________

****

Medicine Form (Mandatory)

I hereby grant Otsar consent and permission for AMAP personnel to administer medication when necessary.

Signature of Parent/Guardian: __________________________________

****

Photo Approval Form

I hereby grant Otsar permission to use visual and audio material of the above participant.

> The purpose of these recordings / photographs is to be used as an educational or therapeutic tool, for informational / publicity use and for our archives and activities.

Signature of Parent/Guardian: __________________________________