Inspiring Personal Independence

SOUTHEAST ALASKA INDEPENDENT LIVING

New Consumer Intake

Name: _____ Date: _____ Date of Birth & Age at Intake: _____

Physical Address: _____ City: _____ Zip: _____ Email Address: _____

Mailing Address (if different): _____ City: _____Zip: _____

Home Phone: _____ Cell Phone: _____ How did you hear about SAIL? _____

Gender: □Male □Female □Transgender □Prefer not to say Preferred pronouns: _____

Primary Language: _____ How would you like to receive SAIL's Newsletter? □Email □Mail □Not interested

Are you registered to vote? □Yes □No (If not, SAIL can help you register.)

Do you have someone who helps you make decisions? Please circle: guardian, conservator, power of attorney, payee, family member, or friend. Please provide their information: Name(s)_____

Contact Information: _____

Can SAIL get a Release of Information for this person/these people? □Yes □No

Ethnicity: Are you of Hispanic, Latino, or Spanish origin? □Yes □No

Race: □African American/Black □Alaska Native (Tribal sub-category: □Aleut □Athabascan □Haida □Inupiat □Tlingit □Tsimshian □Yupik) □Native American □Asian □Hispanic or Latino □Native Hawaiian or Pacific Islander □White □Unknown □Undisclosed □Other_____

Disabilities – Check all that apply (write "P" next to primary disability)

Please describe your disabilities or medical conditions and how they affect your daily life?

___**Alzheimer / Dementia**
___Amputation
___Arthritis
___Asthma
___**Autism**
___Cancer
___Cardiac / Circulatory
___**Cerebral Palsy**
___**Chemical Dependence**:_____
___**Developmental Disability**
___Diabetes
___**Environmental Sensitivities**
___**Epilepsy***
___**Head Injury / TBI**
___Hearing Impairment / Deaf
___High Blood Pressure
___HIV / AIDS
___**Learning Disability**
___**Neurological Condition***
___**Neuromuscular Condition***
___Orthopedic Impairment
___**Mental Health** (e.g.)
__Depression
__PTSD
__Other:_____
___Respiratory Condition
___Speech Impairment
___Spinal Cord Injury
___**Stroke**
___Visual Impairment

Please specify if not listed or add detail_____

_____

_____

Do you need access to assistive technology? □ If so, what could be helpful?_____

Current Services:

Insurance: □Medicare □Medicaid □Private Insurance □Indian Health Services □Veterans Health Care □CAMA □Uninsured

Food Assistance: □Food Stamps (SNAP) □ FDPIR □Meal Service (e.g. Senior Center, Meals on Wheels)

Veteran Status: □Veteran □Receiving VA services? If so, please list: _____

Employment Assistance: □Vocational Rehabilitation (DVR) □Tribal Vocational Rehabilitation (TVR) □Other:_____

Who is your primary medical provider? _____

Have you had any evaluations in the past 3 years or are you receiving mental health/psychiatric care, speech therapy, occupational therapy, physical therapy, etc.?_____

Have you gone through Development Disability Determination in the past? _____

If applicable, do you have/did you have a special education teacher? If so, what is his/her name? _____

Care Coordination or Case Management: □Yes □Needed □Agency _____

Name of case manager / care coordinator: _____Can SAIL get a Release of Information for this person? □Yes □No

Please circle/write in your answers below:

Education (highest level):	**Employment:**	**Income Sources:**	**Monthly Income:**	**Annual Income:**
No Education	Full-time (>min. wage)	Employment		$0-$4,600
Special Education	Part-time	SSI		$4,601-$6,600
8th Grade or Less	Not employed-seeking	SSDI		$6,601-$10,000
Some High School	Not employed-not seeking	Retirement		$10,001-$15,000
GED	Retired	Senior Benefit		$15,001-$20,000
High School Diploma	Self-employed (FT or PT)	Adult Public Assistance (APA)		$20,001-$30,000
Some College	Supported Employment	ATAP/ Interim Assistance/ Workers Comp		$30,001-$40,000
College Degree	Sheltered Employment (<min. wage)	VA Pension/Compensation		Above $40,000
Some Graduate Work	Volunteering	Disability Pension		
Graduate Degree		Native Dividend		
		Unemployment		

Acronym Key: Chronic & Acute Medical Assistance (CAMA), Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), Alaska Temporary Assistance Program (ATAP) & Food Distribution Program on Indian Reservations (FDPIR): This is available in many communities for Natives and non-Natives.

Current Housing Situation:

Do you feel safe in your home (physically, emotionally, etc.)? □Yes □No (If not, please discuss with SAIL staff.)

Type of living situation: □Own House/Apt. □Rent House/Apt. □Parent/Guardian □Group Home □Primary Care Facility □Hotel

□Transitional Housing □Homeless □Living w/family/friends □Institution (nursing home) □Single Room Occupancy (SRO)

Do you have the following at home? □Sufficient water □Heat □Electricity □Internet

Is your housing subsidized? □Yes □No □Subsidy needed Is your housing accessible? □Yes □No □Accessibility needed

If living in an institution, do you live there by choice? □Yes □No Do you plan on moving into assisted living/nursing home? □Yes □No

Do you have a caregiver? □Yes □Not needed □Caregiver needed: Type of caregiver?_____

Transportation:

Do you have transportation? □Yes □No □None available * Type of transportation you have or would like:_____

Eligibility Statement

With the signature of the SAIL staff below, it is certified that the applicant *experiences a significant disability.* A significant disability is any disability that, without using medication or equipment or other aids and services, impacts your ability to participate in life in your community, at work, and/or at home. SAIL Staff Signature _____ Date _____

Client Assistance Program

I acknowledge that SAIL staff explained the purpose of the **Client Assistance Program** (CAP) to me and provided contact information for offices statewide. **Please initial X_____**

I want to create an Independent Living Plan (a goal why I use SAIL services): □Yes **Initial X_____** **OR** I waive my right to create an Independent Living Plan, I understand that I can create an IL Plan in the future if I choose: □Yes **Initial X__**

X_____ X_____

Consumer Signature **Date**

_____

SAIL Staff Signature Date

_____

POA or Parent or Guardian (If Applicable) Date

For Office Use Only

MiCIL Date:_____ ROI(s)___ Photo Release_____ IL Plan ___ ORCA: DSUSA Waiver_____ Activity Form_____