



Jewel Human Services, Inc.

163 Buscher Ave, 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 Health 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 Care Management? : No ___ Yes ___ If yes, please provide the following information:

Agency: _____ Name of Care Manager: _____

Address: _____ Phone #: _____ Email _____

Which services are you interested in at Jewel Human Services?

(Please check all that apply)

Medicaid Service Coordination	Day Habilitation (WOW)	Community Habilitation
After-school Respite	Respite	
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 (e.g. – 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 (e.g – 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
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Intake Conducted By:

Name	Title	Signature	Date
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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	

04/10/ 2016

Revised: 12/15/2025, 09-8-2026