INTAKE DATE: ____/____/____ ____

______________________ **ID#:** _____________________ ___________________________

CONSUMER PROFILE

Last Name: ________________________________ **First Name:** ______________________ **MI:** _____

Resident Address: ____

________________________________ **Zip:** _______________**County:** ____________________

Mailing Address: ____

________________________________ **Zip:** _______________**County:** ____________________

Home Phone: (______)____________________ **Work Phone:** (______)____________________

Cell Phone: (______)______________________

Other Phone: (______)____________________ Specify: ___________________________________

Preferred Contact: ____

Do you want to receive email from WNYIL? (Email list is kept confidential and will not be given out to other sources) ❒ Yes ❒ No

Email Address: ____

Do you *not* want to be contacted by WNYIL for either of the following?

❒ Fundraising ❒ Marketing

Do you require reasonable accommodation for correspondence: ❒ Yes ❒ No

❒ Braille ❒ Large Print ❒ Email ❒ Other _______________________________

Consumer Eligibility:

❒ Has a significant physical or mental impairment, whose ability to function independently in the family or community or whose ability to obtain, maintain, or advance in employment is substantially limited, and/or for whom the delivery of independent living services will improve the ability to function, continue functioning, or move towards functioning independently in the family or community or to continue in employment, respectively.

Primary Disability: ______________________________________

(Choose all that apply)

A. ☼ **Cognitive**

1. ❒ Intellectual Disability
2. ❒ Traumatic and other brain injuries
3. ❒ Learning Disability
4. ❒ Autism
5. ❒ Other cognitive disabilities

B. ☼ **Physical**

6. ❒ Spinal cord injury
7. ❒ Neuromuscular
8. ❒ Orthopedic
9. ❒ Cerebral Palsy

10. ❒ Spina bifida
11. ❒ Other congenital birth anomaly
12. ❒ Epilepsy
13. ❒ Muscular dystrophy
14. ❒ Amputation
15. ❒ Back injury
16. ❒ HIV/AIDS
17. ❒ Environmental and other related illnesses
18. ❒ Other physical disabilities

C. ☼ **Mental/Emotional**

19. ❒ Mental Illness
20. ❒ Emotional/behavioral disabilities
21. ❒Substance Abuse
22. ❒ Other mental illnesses

D. ☼ **Vision**

23. ❒ Blindness
24. ❒ Low vision

E. ☼ **Hearing**

25. ❒ Deafness
26. ❒ Hard of hearing

F. ☼ **Multiple disability**

27. ❒ Deaf/Blind
28. ❒ Combination of above listed or other disabilities

G. ☼ **Other** Please Specify:____

Date of Birth:___ _________/___ _____/_____ _____

Gender: ❒ Female or ❒ Male

SS# (Last 4): _______________

Primary Language: ____

Are you a veteran? ❒ Yes ❒ No

Contact Name:_________________________________

OPWDD? ❒ Yes ❒ No

TABS #: _________________ Contact Name:_____________________________

Are you registered to vote? ❒ Yes ❒ No

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

Would you like to complete an Emergency Preparedness Plan? ❒ Yes ❒ No

Would you like to be considered to be on the Board of Directors or Advisory Councils? ❒ Yes ❒ No

Are you interested in information on health homes? ❒ Yes ❒ No

Race/Ethnicity (choose all that apply):

A. ❒ American Indian or Alaskan Native
B. ❒ Asian
C. ❒ Black or African American
D. ❒ Hispanic or Latino
E. ❒ Native Hawaiian or Other Pacific Islander
F. ❒ White

Last School Completed:

A. ❒ K-8
B. ❒ Some High School
C. ❒ Completed High School
D. ❒ Some College
E. ❒ Business, Trade, Vocational School
F. ❒ 2 Yr Undergrad Degree
G. ❒ 4 Yr Undergrad Degree
H. ❒ Post Graduate Degree
I. ❒ Unknown or Not Yet Enrolled in School

Employment Status:

A. ❒ Full-time
B. ❒ Part-time
C. ❒ Looking for job
D. ❒ Unemployed, not looking for work
E. ❒ Student or in training program
F. ❒ Retired
G. ❒ Segregated work or day program setting
H. ❒ Other not listed above
I. ❒ Unknown

Services Requested:____

Reviewer: ____