



Westchester Institute for Human Development

Assistive Technology REGISTRATION PACKET School

Welcome to the Westchester Institute for Human Development (WIHD). The attached Registration Packet must be completed prior to the patient's first appointment.

The following information is required to be completed:

WIHD PAPERWORK

- Registration Form
- ATP Initial Intake Form
- Consent for Care and Treatment
- Cancellation and Missed Appointment Agreement

****PLEASE COMPLETE AND MAIL/FAX/EMAIL THIS REGISTRATION PACKET AS SOON AS POSSIBLE TO:**

**AT Program
Westchester Institute for Human Development
Cedarwood Hall – Room 422
20 Plaza West (GPS)
Valhalla, New York 10595
Ph: 914-493-1317
Fax: 914-493-3964
atp@wihd.org**

If you have questions feel free to contact us.



REGISTRATION FORM

Today's Date ____/____/____ WIHD ACCOUNT NO. _____

PATIENT INFORMATION

Patient's Last Name	First	Middle	<input type="checkbox"/> New Registration <input type="checkbox"/> Registration Update	Preferred Language
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Social Security #	Race/Ethnicity (for gov't reporting) <input type="checkbox"/> White <input type="checkbox"/> Black/African Am <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Other	Birth Date / /	Age	Sex
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Residential Agency & House (if Applicable)	Phone No. ()	Fax (if available) ()
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Street Address (Home or Residential Agency)	City	State	ZIP Code
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Agency Contact Name (if Applicable)	Email Address	Pharmacy Name & Address
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Does he/she have a Health Care Proxy or other form of Advance Directive (MOLST, Living Will, DNR)? (If over 18 years old) Yes No
 If Yes, Does WIHD have a copy?(required) Yes No *If you would like more information please speak with your provider.

Primary Care Provider	Phone No.	Dental Care Provider	Phone No.
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*If New Registration please indicate service requested: _____

FAMILY/GUARDIAN INFORMATION

Parent/Guardian/Foster Parent Name (1)	Relationship to Patient	Home Phone No. ()	Work Phone No. ()
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Street Address	City	State	ZIP Code
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Email Address	Do you have Guardianship? (If over 18 yr. old) <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Does WIHD have a copy of papers (required)? Yes / No
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Parent/Guardian/Foster Parent Name (2)	Relationship to Patient	Home Phone No. ()	Work Phone No. ()
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Street Address	City	State	ZIP Code
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Email Address	Do you have Guardianship? (If over 18 years old) <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Does WIHD have a copy (required)? Yes / No
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Mother's Maiden Name (if Applicable)	Preferred Contact Instructions
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INSURANCE INFORMATION

(PLEASE LIST ALL INSURANCES AND SUBMIT INSURANCE CARD OR COPY WITH FORM)

Medicaid No.	Medicare No.
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Private Insurance Co. (1)	Policy No.
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Name of Insured	Relationship to Patient
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Private Insurance Co. (2)	Policy No.
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Name of Insured	Relationship to Patient
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ASSISTIVE TECHNOLOGY EVALUATION TEAM

INITIAL INTAKE FORM

Please complete and return to:

Assistive Technology Program
Westchester Institute for Human Development
20 Plaza West - 422 Cedarwood Hall
Valhalla, NY 10595-1689
Email: atp@wihd.org
Tel# 914-493-1317
Fax# 914-493-3964

Date: _____

1) Name of Applicant: _____ DOB _____

Address: _____

Phone: _____ Email: _____

Is applicant in school? [] Yes [] No

If yes, school & grade: _____

Is applicant employed? [] Yes [] No If yes, employer: _____

2) Parent/Guardian/Spouse (if applicable): _____

Address: _____

Home Phone: _____ Cell Phone: _____ E-mail: _____

3) Primary Contact (for appointments etc.): _____

4) Physician: _____

Address: _____

5) Reason for Referral: _____

6) Medical Diagnosis and/or Functional Concerns: _____

7) Please identify any health concerns that are pertinent to the evaluation.



Westchester Institute for Human Development

- hearing loss seizures vision problems recurring health problems
 medications other: _____

Explanation of checked items: _____

- 8) Current AT equipment being utilized in home, school and/or work environment. (communication device, switches, expanded keyboards, software, walkers, wheelchairs etc.)

- 9) Does the individual have any activity interests and preferences (e.g., games) or sensory preferences (colors, lights, sounds): _____

- 10) List specific concerns or questions you want addressed in this evaluation: _____

- 11) Is there any other information that you feel we should know: _____

Please fill out APPLICABLE PORTIONS ONLY of the remaining pages. Thank you.



FUNCTIONAL OVERVIEW

1) Has the individual ever received speech/language therapy? _____
How does the individual generally make himself/herself understood (e.g., speech, gestures, graphic cues, object cues, vocalizing)? _____

2) Does the individual presently receive speech/language therapy? _____
Please describe the time period, frequency of service, and major goals in therapy:

SLP's name & phone: _____

3) How do you communicate with the individual?

Verbal alone: _____

Verbal with visual cues: _____

4) What kinds of information does the individual communicate spontaneously?

5) Please identify specific means of communicating:

- | | | |
|---|---|---|
| <input type="checkbox"/> facial expressions | <input type="checkbox"/> gestures/informal signs | <input type="checkbox"/> behavior |
| <input type="checkbox"/> sign language | <input type="checkbox"/> sounds | <input type="checkbox"/> alphabet board |
| <input type="checkbox"/> words | <input type="checkbox"/> non-electronic communication | |

6) How does the individual gain your attention when you are not paying attention to him/her?

7) How does the individual ask questions for directions, information and personal needs?



8) How does the individual communicate choices or indicate preferences?

9) Does this client have a recognizable way to indicate yes/no? _____

If yes, please describe: _____

10) Please describe major educational setting(s) and major emphasis in program.

11) Cognitive Level: _____

Reading Level: _____

Writing Skills: no ability legible handwriting keyboarding skills

Motor Abilities: ambulatory functional hand use functional head use

volitional controlled movement of body part (explain):

12) Does this individual presently receive OT? _____

Please describe the time period, frequency of service, and major goals in therapy:

OT's name & phone: _____

13) Does the individual presently receive PT? _____

Please describe the time period, frequency of services, and major goals in therapy:

PT's name & phone: _____

****Please forward any pertinent PT, OT and/or Speech Reports along with any current IFSP/IEP or vocational reports.***



Westchester Institute
for Human Development

NAME _____

D.O.B. _____

WIHD # _____

Consent for Care and Treatment
ASSISTIVE TECHNOLOGY PROGRAM

1. I hereby authorize _____ to participate in an Assistive Technology Evaluation and/or Training at the Assistive Technology Program at WIHD.
2. I acknowledge that no guarantees or assurances are made to me concerning the implementation of recommendations resulting from this evaluation by third parties.
3. I confirm that I have read and fully understand the above, and have been given the opportunity to ask questions, and that all my questions have been answered fully and to my satisfaction.

Patient/Relative/Guardian or Personal Representative

Signature of Parent/Guardian/Personal Representative

Print Name of Parent/Guardian/ Personal Representative

Date

Description of Personal Representative's Authority

Interpreter (if required)

Signature

Print Name



NAME _____

D.O.B. _____

WIHD # _____

Cancellation and Missed Appointment Agreement

We, at Westchester Institute for Human Development (WIHD), understand that sometimes you need to cancel or reschedule your appointment. If you are unable to keep your appointment, please notify us as soon as possible. Missed or late appointments disrupt schedules that can impact you and other patients.

To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit on time. As a courtesy, an appointment reminder call or email to you is made/attempted 1 business day prior to your scheduled appointment. However, it is your responsibility to arrive for your appointment on time.

PLEASE REVIEW THE FOLLOWING POLICY

1. We ask that you please cancel your appointment with at least 24 hours' notice. This will enable us to accommodate other patients who are requesting similar time slots.
2. If you are more than 15 minutes late it is possible we may not be able to accommodate you. If you will be late please call in advance to make sure you can still be seen for the remainder of your appointment.
3. All late cancellations and no shows will be documented in your medical record.
4. Three or more late cancellations or no shows in a 3 month time frame may result in terminating services.
5. If there is a one-month lapse in treatment for services requiring ongoing consecutive sessions, without discussing with the clinician in advance, treatment may be terminated.
6. Please be aware that if your case is closed you may be placed on a waiting list and the same clinician or time slot cannot be guaranteed.
7. We will make every attempt to contact you after late cancellations and no shows. These attempts to contact you will be documented in your medical record.
8. If your services are terminated due to missed appointments we will attempt to assist you by recommending alternative providers.

I have read and understand WIHD's Cancellation and Missed Appointment Policy and understand my responsibility to plan appointments accordingly and notify WIHD appropriately if I have difficulty fulfilling my scheduled appointments.

Signature of Patient/Guardian

Date

Printed Name

Relationship to Patient (if applicable)

DIRECTIONS TO WESTCHESTER INSTITUTE FOR HUMAN DEVELOPMENT (WIHD)

**ASSISTIVE TECHNOLOGY DEPARTMENT – 914-493-1317
4TH FLOOR, ROOM 422**

GPS

20 Hospital Oval West
Valhalla, NY

FROM THE BRONX AND SOUTH:

Bronx River Parkway North to Sprain Brook Parkway North. Exit at Medical Center exit. Turn left onto Hospital Road. Continue straight at stop sign, following road past parking structure on your left to the end of the road. At stop sign, turn left and then make first right, following blue signs for Cedarwood Hall/WIHD. Take ticket at gate; follow road in front of Cedarwood Hall, then turn left into parking area.

FROM THE NORTH:

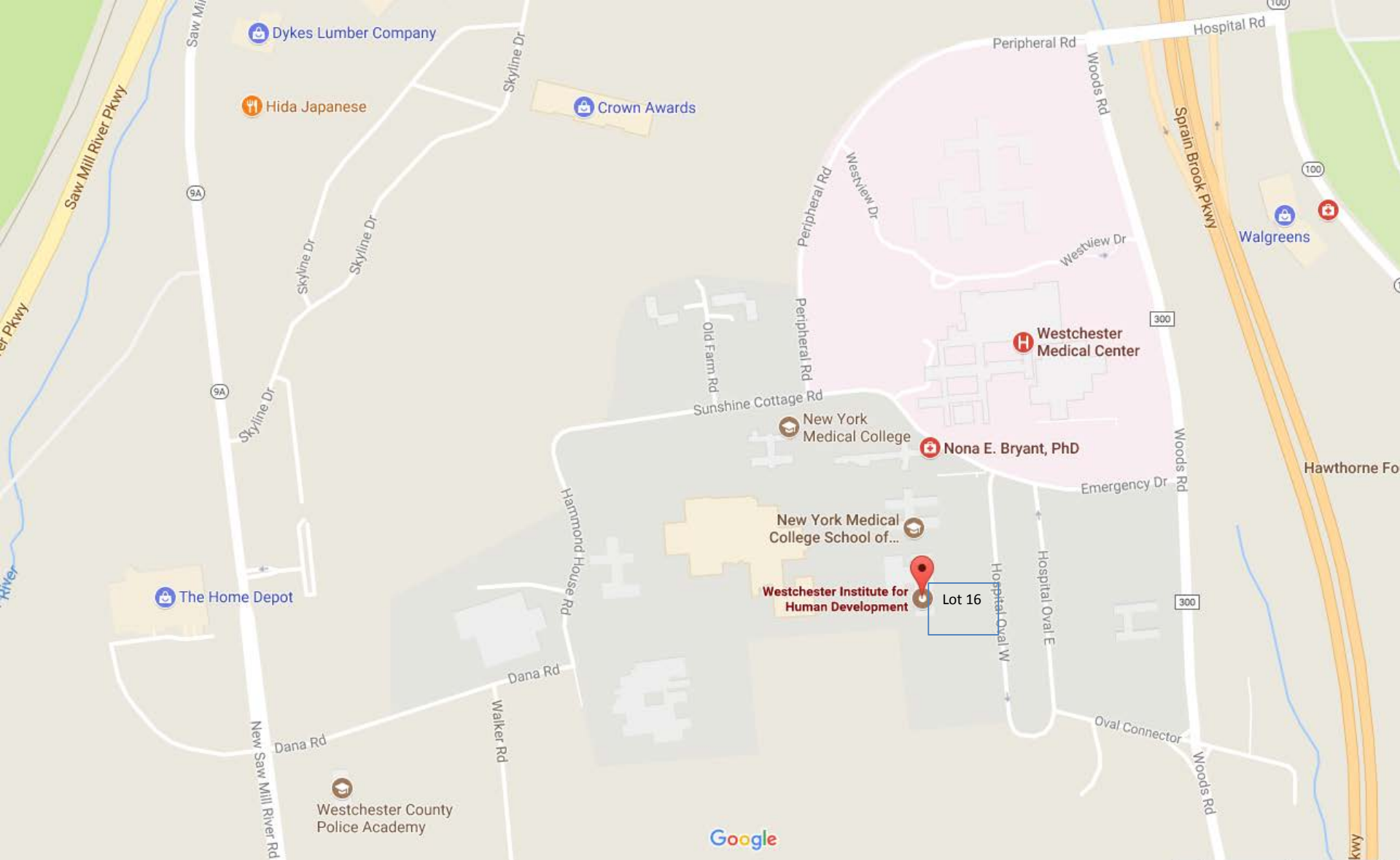
Taconic Parkway South to Medical Center/Route 100 exit (just past the New State Police Headquarters). Turn right at top of exit ramp onto Route 100 South. Turn right at light, passing over parkway. Continue straight at stop sign, following road past parking structure on your left, to the end of the road. At stop sign, turn left and then make first right, following blue signs for Cedarwood Hall/WIHD. Take ticket at gate; follow road in front of Cedarwood Hall, then turn left into parking area.

FROM THE WEST:

New York State Thruway South across Tappan Zee Bridge staying to the right as you go through tolls to Exit 8A (87 South). Follow signs for Saw Mill River Parkway North. Exit at Eastview, and turn right. Follow road through business park, remaining on Route 100C (bear left) as road forks. At second light, make a left into the Westchester Medical Center campus and follow road to stop sign at end. Turn left, following road past parking structure on your left to the end of the road. At stop sign, turn left and then make first right, following blue signs for Cedarwood Hall/WIHD. Take ticket at gate; follow road in front of Cedarwood Hall, then turn left into parking area.

FROM THE EAST:

Cross Westchester Expressway (287) Westbound to Exit 3 (Sprain Parkway). Bear left after exiting to Northbound Sprain. Take Sprain Parkway north to Medical Center exit. Turn left onto Hospital Road. Continue straight at stop sign, following road past parking structure on your left, to the end of the road. At stop sign, turn left and then make first right, following blue signs for Cedarwood Hall/ WIHD. Take ticket at gate; follow road in front of Cedarwood Hall, then turn left into parking area.



Dykes Lumber Company

Hida Japanese

Crown Awards

Peripheral Rd

Hospital Rd

Saw Mill River Pkwy

9A

9A

The Home Depot

New Saw Mill River Rd

Westchester County Police Academy

Dana Rd

Walker Rd

Hammond House Rd

Sunshine Cottage Rd

New York Medical College

New York Medical College School of...

Westchester Institute for Human Development

Lot 16

Old Farm Rd

Peripheral Rd

Westview Dr

Westview Dr

Emergency Dr

Hospital Oval W

Hospital Oval E

Oval Connector

Woods Rd

Woods Rd

Woods Rd

300

300

300

300

100

100

100

100

Walgreens

Hawthorne Fo

Google