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 421
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.

Westchester Institute for Human Development

REGISTRATION FORM

Today's Date _____/_____/_____ | WIHD ACCOUNT NO_____

PATIENT INFORMATION

Patient's Last Name	First	Middle	❑ New Registration ❑ Registration Update	Preferred Language

Social Security #	Race/Ethnicity *(for gov't reporting)*	Birth Date	Age	Sex
N/A	❑ White ❑ Black/African Am ❑ Asian ❑ Hispanic/Latino ❑ Other	/ /		

Residential Agency & House (if Applicable)	Phone No.	Fax (if available)
	( )	( )

Street Address (Home or Residential Agency)	City	State	ZIP Code

Agency Contact Name (if Applicable)	Email Address	Pharmacy Name & Address

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.

***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.
		( )	( )

Street Address	City	State	ZIP Code

Email Address	Do you have Guardianship? (If over 18 yr. old) ❑ Yes ❑ No If Yes, Does WIHD have a copy of papers (required)? **Yes / No**

Parent/Guardian/Foster Parent Name (2)	Relationship to Patient	Home Phone No.	Work Phone No.
		( )	( )

Street Address	City	State	ZIP Code

Email Address	Do you have Guardianship? (If over 18 years old) ❑ Yes ❑ No If Yes, Does WIHD have a copy (required)? **Yes / No**

Mother's Maiden Name (if Applicable)	Preferred Contact Instructions

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

Medicaid No.	Medicare No.
N/A	N/A
Private Insurance Co. (1)	Policy No.
N/A	N/A
Name of Insured	Relationship to Patient
N/A	N/A
Private Insurance Co. (2)	Policy No.
N/A	N/A
Name of Insured	Relationship to Patient
N/A	N/A

Westchester Institute for Human Development

ASSISTIVE TECHNOLOGY EVALUATION TEAM

INITIAL INTAKE FORM

Please complete and return to:

Assistive Technology Program
Westchester Institute for Human Development
20 Plaza West - 421 Cedarwood Hall
Valhalla, NY 10595-1689
Email: atp@wihd.org
Tel# 914-493-1317
Fax# 914-493-3964

Date:_____

1) Name of Applicant:_____DOB_____

   Addresss:_____

   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.

[ ] 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.

Westchester Institute for Human Development

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:

[ ] facial expressions	[ ] gestures/informal signs	[ ] behavior
[ ] sign language	[ ] sounds	[ ] alphabet board
[ ] words	[ ] 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

Westchester Institute for Human Development

NAME _____

D.O.B. _____

Cancellation and Missed Appointment Agreement

WIHD # _____

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 421

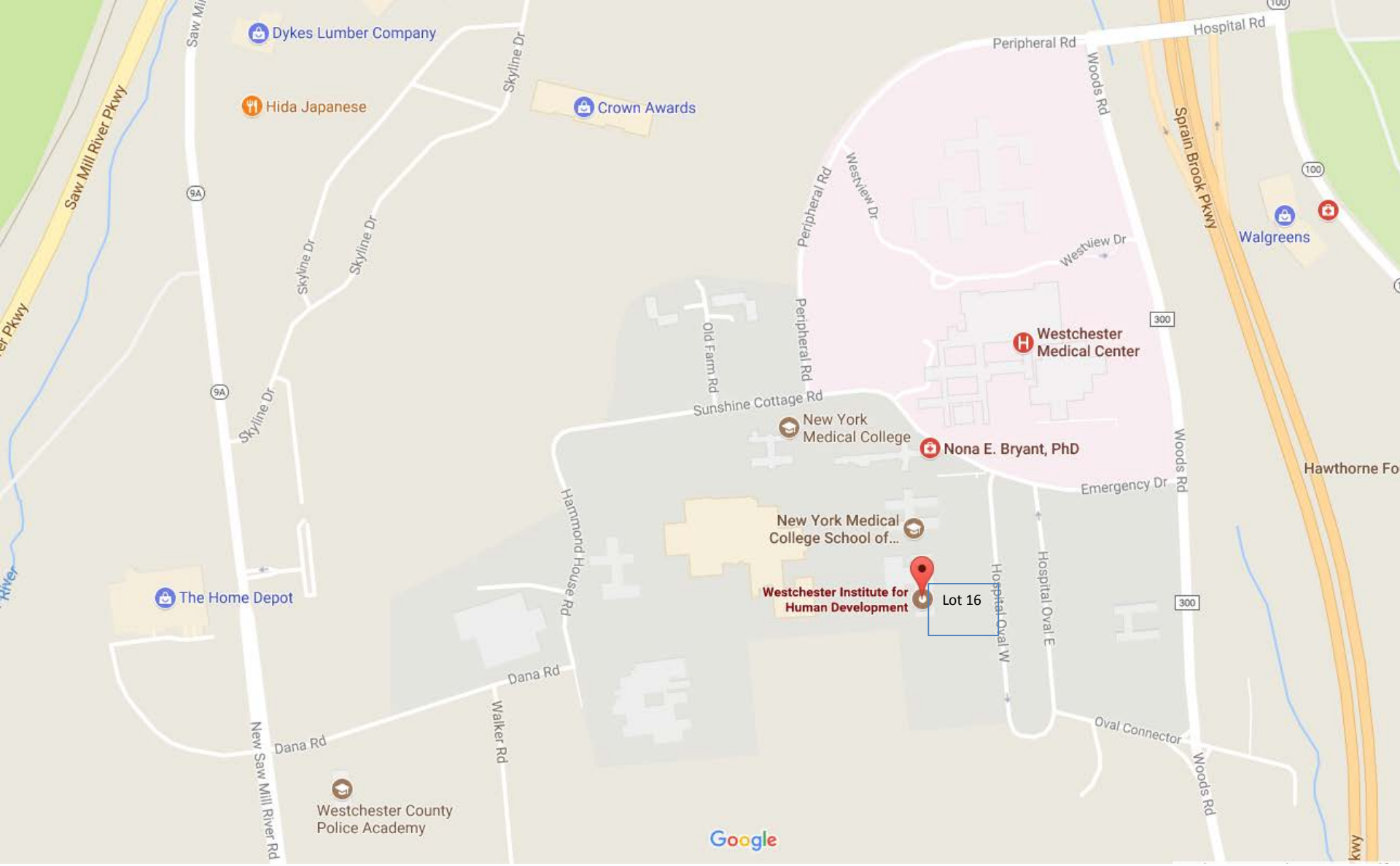
GPS
20 Hospital Oval West
Valhalla, NY

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
Saw Mill River Pkwy
Skyline Dr
9A
Peripheral Rd
Hospital Rd
Woods Rd
Sprain Brook Pkwy
100
Walgreens
Westview Dr
Old Farm Rd
Sunshine Cottage Rd
300
Westchester Medical Center
New York Medical College
Nona E. Bryant, PhD
Emergency Dr
Hawthorne Fo
New York Medical College School of...
Westchester Institute for Human Development
Lot 16
Hammond House Rd
Hospital Oval W
Hospital Oval E
Oval Connector
The Home Depot
Dana Rd
Walker Rd
New Saw Mill River Rd
Westchester County Police Academy
Google