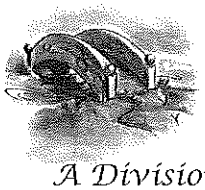


New Journeys

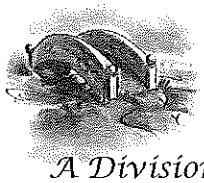
A Division of Kee to Independent Growth, Inc.
425 C Eastline Road Ballston Spa NY 12020
Phone(518) 309-3557 **Fax**(518) 309-3558

Thank you for your interest in New Journeys Day Program!

If you would like to set up a tour please call and schedule a time to visit our site. If you are interested in spending an orientation day with us please complete, or have your Service Coordinator or family member complete, the following application. A physical and other documentation listed on the application are not necessary for a tour or orientation day however, will be required before acceptance/attendance to program can begin.

Please do not hesitate to call if you have any questions or need help filling out this application.

Email completed applications to:
Manager Kelly at
Khanafin@kigiservices.com



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Phone(518) 309-3557 **Fax**(518) 309-3558

☐TBI ☐NHTD

Date of Referral:_____ Start Date:_____

Name:_____

Address: _____

Phone:_____

Date of Birth_____ ☐Male ☐Female

Living Arrangement: ☐Alone ☐W/Spouse ☐W/Relatives ☐W/Non-Relatives

Social Security Number:_____

Medicaid Number:_____

Medicare Number:_____

Other Insurance Company and ID:_____

Emergency Contact Name:_____

Address:_____

Phone:_____

Relationship to Emergency Contact:_____

Primary Care Physician:_____

Address:_____

Phone:_____Fax:_____

Pharmacy:_____

Address:_____

Phone:_____Fax:_____

Allergies/Reactions:_____

_____

Area Hospital of Choice:_____

Use a Wheelchair? ☐Yes ☐No Type? ☐Manual ☐Automatic

Able to climb stairs? ☐Yes ☐No ☐With Help from Staff

Diabetic: ☐Yes ☐No If yes, are Insulin Injections taken? ☐Yes ☐No

If yes, are you self-administering? ☐Yes ☐No

Seizures: ☐Yes ☐No If Yes, Date of Last Seizure_____

Type:_____ Frequency:_____

DNR☐ Health Care Proxy☐ (If yes to either provide copy for Grab & Go)

Service Coordinator:_____

Email:_____

Agency:_____

Address:_____

Phone:_____ Fax:_____

Days Interested In Attending: ☐Mon. ☐Tu. ☐Wed. ☐Thurs. ☐Fri.

Transportation Company: _____

Transportation Phone:_____ Fax:_____

Transportation Needs/Options (If one not yet set up): _____

_____

_____

Diagnoses:_____

_____

_____

History:_____

_____

_____

Physical Limitations:_____

_____

Dietary Restrictions:_____

_____

Behavioral Concerns:_____

_____

Any difficulties with:

☐Visual ☐Hearing ☐Speech

Explain:_____

Please Identify Level of Assistance Needed In The Following Areas:

Mobility:_____

_____

Dining:_____

_____

Toileting:_____

_____

Medication:_____

_____

Self-Care:_____

_____

Communication:_____

_____

Current medications, dose, time of day taken, and reason for being prescribed the medication:

Medication	Dosage	Time of Day	Reason

Current Medications, dosage and time of day taken:

Medication	Dosage	Time of Day	Reason

Current Therapies/Services Received:

☐ OT Agency/Dr.:_____ Phone:_____

☐ PT Agency/Dr.:_____ Phone:_____

☐ Speech Agency:_____ Phone:_____

☐ ILST Agency:_____ Phone:_____

☐ HCSS Agency:_____ Phone:_____

☐ CIC Agency:_____ Phone:_____

Other: Service:_____

Agency/Dr.:_____ Phone:_____

Other: Service:_____

Agency/Dr.:_____ Phone:_____

Additional Info:_____

_____

_____

_____

_____

_____

Name of Person Completing Application:_____

Relationship to Applicant:_____

The Following Are Required Before Attendance to Program:

- ☐ Current physical (within the last year)
- ☐ Two-Tier Negative PPD within the last year OR Negative IGRA Blood test results within the last year OR if positive in the past we require a doctor letter and chest X-Ray
- ☐ Copies of Insurance (front & back) for billing purposes
- ☐ Copy of DNR or Health Care Proxy (if applicable)
- ☐ ORIGINAL ISP Packet in its entirety (Rights, Freedom of Choice, Etc.)
- ☐ Recent RSP Packet
- ☐ Current UAS-NY & PRI/Screen (if applicable)
- ☐ NOD for Structured Day Program along with Addendum or Change of Vendor