

Westchester Independent Living Center, Inc.

Front Desk Intake

Date of call or visit ___/___/___

First Name _____ Last Name _____ MI _____

Address _____ Apt. _____

City _____ State _____ Zip _____ County _____

Home # (____) _____ Work (____) _____ Cell (____) _____

E-mail _____

1. How do you prefer we contact you? Home Phone Cell Phone Email
 By Mail Other _____

2. Are you Male Female?

3. Do you need interpreter services? ASL Spanish Other _____

4. Where did you hear about us?

Hospital Friend/Family Access-VR Newspaper

School Cable Internet Other (specify) _____

5. Are you a Person with a disability?

Friend or Family member of a person with a disability?

(Skip question 6)

Professional working with someone with a disability?

(Skip question 6)

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6. What disabilities do you have?

A. Cognitive: Mental Retardation Traumatic & Other Brain Injuries

Autism Learning Disability Other Cognitive_____

B. Physical: Spinal Cord Injury Neuromuscular Orthopedic

Back Injury Spinal Bifida Muscular Dystrophy Cerebral Palsy

Epilepsy HIV/AIDS Amputation Environmental

Congenital Birth Anomaly Other Physical _____

C. Mental: Mental Illness Emotional/Behavioral Illness

Substance Abuse Other Mental Illness_____

D. Sensory: Blindness Low Vision Deafness Hard of Hearing

Deaf/blind Other Sensory_____

7. What kind of help do you want, what information are you looking for, why did you contact us?