ANIBIC Center Intake Department
61-35 220th Street • Bayside, NY 11364 • (718) 423-9550 ext. 2147

Date: _____

Please return completed application along with current medical, PPD (both within 1 year), Psychological (IQ) and Psychosocial evaluations to document disability.

Applicant Information:

Name _____

Address _____

_____

Telephone (_____) _____-_____ Cell Phone (_____) _____-_____

Date of Birth ___/___/___ Social Security #_____-____-_____ Medicaid #_____

Does the applicant have service coordination? □ Yes □ No

If yes, please complete below:
Service Coordinator: _____Phone (_____) _____-_____

Service Coordination Provider Agency: _____

Contact Information

Name _____

Address _____

_____

Telephone (_____) _____-_____ Cell Phone (_____) _____-_____

E-mail _____@_____

I am interested in the following ANIBIC Programs & Services:

PROGRAM	MEETING TIME	AGE RANCE	LOCATION
For Family Reimbursement applications, call Intake or Rachel Platkstis at 347-594-2130.			
□Young Adult	Friday, 7:00-10:30 PM	17+	ANIBIC Center
□Weekend Respite	Alternating Saturdays & Sundays, 11-4 PM	18+	ANIBIC Center
□Tutorial Program	Varied	6 to adult	ANIBIC Center
□Day Habilitation		18+	ANIBIC Center
□Day Habilitation		50+	Iris Hill
□Vocational Services	□Residential Waiting List	□Family Counseling	
Service Coordination:	Medicaid □	Non-Medicaid □	

Name/relationship of individual completing app. (Please print) _____

Signature _____

ANIBIC
Association for Neurologically Impaired Brain Injured Children, Inc.
61-35 220th Street • Oakland Gardens, NY 11364
Phone: (718) 423-9550 Fax: (718) 423-4010

MEDICAL EXAMINATION

Name				Date of Exam					
Allergies				DOB			Age		
Height		Weight		Blood Pressure		Pulse		LMP	

MEDICAL PROBLEMS	MEDICATIONS	RXS WRITTEN

PHYSICAL EXAM							
Head:			Teeth:			Breasts:	
Eyes:	Vision:		Skin:			Abdomen:	
Ears:	Hearing:		Heart:			Genitalia:	
Nose:			Lungs:			Hernia:	
Throat:			Thyroid:			Neurological Findings:	

HEALTH HISTORY (PLEASE CHECK ALL THAT APPLY WITH APPROPRIATE DATES)					
Ear Infections: _____	Asthma: _____	Rheumatic Fever: _____	Chicken Pox: _____	Convulsions: _____	
High Blood Pressure: _____	Diabetes: _____	Other:			
ALLERGIES: Hay Fever: _____	Insect Bites: _____	Penicillin: _____	Other (List):		
Medications (List): _____	Food (List): _____				
1. Operations or Serious Injuries:					
2. Hospitalizations:					
3. Chronic or reoccurring illness:					
4. Are there any restrictions on person's activities? Yes____ No____ If yes, please specify					
5. Are there any restrictions to this person being placed in the community? Yes____ No____ If yes, please specify					

HEALTH MAINTENANCE (enter date, or ✓if done today, or WS for "will schedule")						
Immunizations	TB:	Flu:	Pneumovax:	Hep.B:	Hep.C:	Varicella:
	PPD Status:	Date of PPD:	Results:	History of B Vaccine Series:		
Lab	CBC	Chem	TSH	PSA	Lipid Profile	
	U/A	Hemocculls		Other		
Pap		GC/CT				
Mammogram		Bone density				
Flex. Sig.		Treadmill		Ophthalmology		

OTHER RECOMMENDATIONS / REFERRALS			
Follow-up		Next Physical	

_____
Examining Physician's Signature

Please Stamp Here