



New Participant Intake Registration Packet

Participant Information:

Last Name: _____ First Name: _____ Age: _____

DOB: ___/___/___ TABS#: _____ Medicaid#: _____

Address: _____ Zip: _____

City: _____ State: _____

Gender: _____ Race/Ethnicity: _____

Parent/Guardian Information #1:

Parent/Guardian Name: _____

Relationship to Participant _____ Cell Phone: _____

Home Phone: _____ Work Phone: _____

Parent/ Guardian Email: _____

Parent/Guardian Information #2:

Parent/Guardian Name: _____

Relationship to Participant _____ Cell Phone: _____

Home Phone: _____ Work Phone: _____

Parent/ Guardian Email: _____



Emergency Contacts:

Please list below persons, **not yourself**, who can be called if we are unable to contact you.

| Name | Relationship to Participant | Phone |
|-------|-----------------------------|-------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

| | | |
|------------|-----------|-------|
| _____ | _____ | _____ |
| Print Name | Signature | Date |



All About the Participant:

School I attend: _____

Grade: _____

Day Habilitation Program I attend: _____

Other Programs I Attend:

Personal / Family Information: Siblings (Names & Ages):

Pets (Types of pets & ages):

Hobbies and/or Activities I like:

Favorite Food/Drinks:



Alerts

Name: _____

Diagnosis: _____

Medical Alerts: (For seizures, please indicate seizure protocol)

N/A _____

Allergies: EpiPen Prescribed? Yes / No

Asthma: Yes / No Inhaler/Nebulizer treatment: Yes /

Fears or Aversions:

N/A _____

How is this best handled?

N/A _____

Behavioral Challenges Behavior Description:

N/A _____

When does this behavior occur?

N/A _____

Does the participant require assistance in the bathroom and/or a bladder or bowel chart?

N/A _____



Intake Form

Does the participant have a waiver eligibility? Yes / No
If yes, please answer the following:

Care Manager Name: _____

Care Manager Agency: _____ Care Manager Phone: _____

Care Manager Email: _____

Does the participant have Self-Direction? Yes / No
Are you in the process of transitioning to Self-Direction? Yes/No
If yes, please answer the following:

Self-Direction Broker Name: _____

Self-Direction Broker Phone: _____

Self-Direction Broker Email: _____

GRACE personnel only:

ICD-10 Code/s for participant: _____

Intake Notes: _____



Intake Information About the Participant:

Does the participant know they have ASD/DD? _____

Would you like staff to address the diagnosis during social skills and/or other programs? _____

Communication Skills:

In what way/s does the participant communicate? *Circle all that apply to the participant.*

Has conversational language

Gestures/Points

Verbal – speaks in sentences

Sign Language

Verbal – one or two words

Leads others to get what is wanted

Communication Device

Independently gets what is wanted

Other: _____

Does the participant use a spell to communicate letter board?

Yes/No-Is the participant toilet trained? Yes / No

How does the participant communicate the need to use the restroom?

Can the participant share an idea? Yes / No

Can the participant use their imagination and then explain their ideas? Yes/No



Social Skills:

How does the participant socialize? *Circle all that apply to the participant.*

- | | |
|---|-----------------------------------|
| Has friends | Can read facial expressions |
| (emotions)Can identify why they are friends | Can read tone of voice (emotions) |
| Plays games with friends | Can read body language |
| Will ask friends questions | Offers help |
| Can follow game rules | Knows when to take turns |
| Shows Empathy | Can resolve a conflict |
| Talks to friends or peers even perspectivethere are adults in the room | Can accept another person's |

Anything particular that the participant has difficulty dealing with?

(For example: Changes in routine; transitions; the word "no"; seated activities; performing tasks; stayingattentive and focused; etc.)

Can the participant problem solve?

Yes/ No

Please explain:



Please explain any behaviors/skills you would like addressed during these programs:

What activities do you think the participant would enjoy learning or doing?

Are there any specific interests the participant has (trains, dinosaurs, movies, history, etc.)?

What makes the participant laugh?



VIDEO/PHOTO RELEASE

I give permission for my son/daughter _____ to be videotaped and/or photographed for materials/promotion of the GRACE Foundation within our agency and for us in print, social media, and all other forms of media.

Permission Granted: YES NO

Parent/Guardian (Please print)

Parent/Guardian Signature

Relation to child

Date



Participant Scheduling & Availability

So that we can get a better understanding of our participants scheduling and availability, please fill out the days and times the participant is available for respite programs (in person only):

Please note that if your son/daughter requires 1:1 supervision, it will depend on the staffing!

| Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
|--|--|--|--|--|--|--|
| Yes / No | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No |
| Time/s of the day available: _____ _____ _____ _____ | Time/s of the day available: _____ _____ _____ _____ | Time/s of the day available: _____ _____ _____ _____ | Time/s of the day available: _____ _____ _____ _____ | Time/s of the day available: _____ _____ _____ _____ | Time/s of the day available: _____ _____ _____ _____ | Time/s of the day available: _____ _____ _____ _____ |

Consent to Participate in Programs at the GRACE Foundation:

Print Name

Signature

Date



Program Availability and Selection

The following categories are implemented into various program curriculums to ensure that interests and personal choices are respected, encouraged, and nurtured. Categories are subject to change and consist of both in-person and online platforms. Please see the program descriptions for further clarification on any programs we offer, if needed.

In-Person Only

Please circle any interests the participant has:

| | | | |
|--|--|---|--|
| <ul style="list-style-type: none"> • Art • Sensory • Social Skills • Health & Wellness • Science • History • Cooking • Animation • Creative Writing • World Culture • Playground Play • Fashion • Problem Solving | <ul style="list-style-type: none"> • Community Service • Acting • Singing • Dancing • Games • Physical Fitness • Travel • Movies/Entertainment • Decision Making • Parties • LEGOs • Trains • Geography | <ul style="list-style-type: none"> • Jokes/Comedy • Ethics • Self-Advocacy • Social Club • Dinner Club • Video Games • Independent Living Skills • Disney • Themed Parties | <ul style="list-style-type: none"> • Trips in the Community • Museums • Money Management • Guessing Games • Art History • Karaoke • Music • Jeopardy |
|--|--|---|--|

Other Services Available:

In-Home Respite

Community Habilitation

If interested in the GRACE Day Habilitation Program, please reach out to: Caroll Berliavsky and/or John Malczewski, Co-Managers of Day Habilitation Services.

Email: (cberliavsky@graceofny.org) Phone: 718-983-3800 ext. 220

Email: (jmalczewski@graceofny.org) Phone: 718-983-3800 ext. 229



**THE GRACE FOUNDATION
2026-2027 MEDICAL CLEARANCE FORM**

Name: _____ Date of Birth: _____
Address: _____ Telephone No.: _____

MEDICAL/PHYSICAL

Height: _____ Weight: _____ Blood Pressure: _____ P. P. D. Result: _____ Date of Last Tetanus: _____

Diagnosis

- | | | |
|---|---|---|
| <input type="checkbox"/> Autism Spectrum Disorder | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Sensory Impairment |
| <input type="checkbox"/> Intellectual Disability | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Neurological Impairment | <input type="checkbox"/> Learning Disabled | <input type="checkbox"/> Traumatic Brain Injury |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> COVID Vaccination Dates (If applicable): _____ | |

Does this individual have Down Syndrome? Yes No

Does this individual have Seizures? Yes No

Seizure Protocol: _____

Physician indicates seizures under control:

Yes No

Indicate satisfactory or explain if problematic:

Vision: _____

Hearing: _____

Cardiovascular: _____

Respiratory: _____

Pulmonary: _____

Current Medications: _____

List any allergies: _____

Epipen: Yes No If yes, can the participant administer it him/herself: Yes No

Limited Physical Restrictions: _____

Uses Adaptive Equipment: _____

List any medical/behavioral/other comments that may warrant our attention: _____

PHYSICIAN'S STATEMENT OF CLEARANCE

On this date _____, I examined the above named individual and my findings indicate that he/she is capable of participating in the GRACE Foundation Programs.

Physician's Signature: _____ **M.D. #** _____

Phone: (____) _____ **Fax:** (____) _____



2026-2027 PPD TEST RESULT FORM

Name: _____ Date of Birth: _____

Address: _____ Telephone No.: _____

Date of Examination: _____

Date of Most Recent PPD Implantation: _____

Date of Most Recent PPD Reading: _____

Results: _____ mm (Check one) Negative: _____ Positive: _____

If Positive: Date of Most Recent CXR: _____ Results: _____

Based on today's evaluation, the above-named individual was found to be free of any sign or symptom of active Tuberculosis.

Name/Stamp of Examiner/Degree

Signature of Examiner

Address

Telephone No.



GRACE FOUNDATION Individual Rights & Responsibilities

Policy

All individuals served by the Grace Foundation have the following rights and responsibilities:

1. No person shall be deprived of any civil or legal right solely because of a diagnosis of developmental disability. (See Glossary)
2. All persons shall be given the respect and dignity that is extended to every person regardless of race, religion, national origin, creed, age, gender, ethnic background, developmental disability, or other handicap.
3. A person shall not be denied:
 - a. A safe and sanitary environment.
 - b. Freedom from unnecessary or psychological abuse.
 - c. Freedom from Corporal Punishment.
 - d. Freedom from unnecessary use of mechanical restraining devices.
 - e. Freedom from unnecessary or excessive medication.
 - f. Protection from commercial or other exploitation.
 - g. Confidentiality regarding all information contained in the person's record, and access to such information, subject to the provisions of Article 33 of Mental Hygiene Law and the commissioner's regulations. In addition, confidentiality regarding HIV related information shall be maintained in accordance with Article 27-F of the Public Health Law, 10 NYCRR Part 63 .and the provisions of section 633.19 of this part.
 - h. A written individual plan of services (see Glossary) which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency; which includes meaningful recreation and community programs and contact with non-handicapped persons; and which enables the person to live as independently as possible. Such right also include:
 - i. The opportunity to participate in the development and modification of an individualized plan of service, unless constrained by the person's ability to do so.
 - ii. The opportunity to object to any provision within an individualized plan of services and the opportunity to appeal any decision, with which the person disagrees, made in relation to his or her objection to the plan.
 - iii. The provision for meaningful and productive activities within the person's capacity although some risk may be involved, and which take into account his or her interests.
 - i. Services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely, and humanely, with full respect for the person's dignity and personal integrity.
 - j. Appropriate and humane health care and the opportunity to the extent possible, to have input either personally or through parent(s), guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion.



- k. Access to clinically sound instructions on the topic of sexuality and family planning services and information about the existence of these services, including access to medication or devices to regulate conception, when clinically indicated. This right includes:
 - i. Freedom to express sexuality as limited by one's consensual ability to do so provided such expression do not infringe on the rights of others.
 - ii. The opportunity to carry a pregnancy to term.
 - iii. The right of facilities to reasonably limit the expression of sexuality including time and location thereof, in accordance with a plan for effective facility management.
- l. Observance and participation in the religion of his or her choice, though the means of his or her choice, including the right of choice not to participate.
- m. The opportunity to register and vote and the opportunity to participate in activities that educate him or her in civic responsibilities.
- n. No person shall be denied freedom from discrimination, abuse or any adverse action based on his or her status as one who is subject for an HIV-related test or who has been diagnosed as having HIV infection, AIDS, or HIV-related illness.
- o. The receipt of information on or prior to admission, regarding the supplies and services that the facility will provide or for which additional charges will be made and timely notification of any changes thereafter.
- p. The use of his or her personal money and property, including regular notice of his or her financial status and the provision of assistance in the use of his or her resources, as appropriate.
- q. Respect for his or her cultural identity.
- r. A balanced and nutritious diet, served at appropriate times and in as normal manner as possible, and which is not altered or totally denied for behavioral management of disciplinary (punishment) purposes.
- s. Individually owned clothing which fits properly, is maintained properly, and is appropriate for age, season and activity, and the opportunity to be involved in the selection of that clothing.
- t. Adequate, individually owned grooming and personal hygiene supplies.
- u. A reasonable degree of privacy in sleeping, bathing, and toileting areas.
- v. No person shall be denied a reasonable amount of safe, individual accessible storage space for clothing and other personal belongings used on a day-to-day basis.
- w. The opportunity to request an alternative residential setting whether a new residence or change of room and involvement in the decision regarding such changes.
- x. The opportunity, either personally or through parent(s), guardian(s), or correspondent, to express without fear of reprisal grievances, concerns, and suggestions to the facility director, the Commission on Quality of Care, and for developmental center residents, the Mental Hygiene Legal Service and the board of visitors.
- y. The opportunity to receive visitors at reasonable times, to have privacy when visited, provided such visits avoid infringement on the rights of others, and to communicate freely within or outside the facility.

Purpose, Goals, and Objectives: The New York State Office for People with Developmental Disabilities (NYS-OPWDD) HCBS Waiver was initiated in 1991 creating a new service provision model that encouraged increased use of community resources to meet the needs and enrich the lives of persons with developmental disabilities. The initial goal of the waiver was to serve more people with a wider range of community-based services that were more individualized and less

expensive than institutional care. This goal continues to be a central focus of OPWDD's waiver which today continues to provide the framework within which individualization and "putting people first" have been put into practice. Waiver



participants, their families, the non-profit provider community, and state authorities continue to collaborate to create a person-centered service environment that is innovative and focused on community resources and self-direction principles. OPWDD's customers have made it clear that they want a "life, not a program" and a real life is based on four primary person-centered outcomes that support OPWDD's mission of "helping people lead richer lives". An important goal of OPWDD's HCBS waiver is to facilitate these outcomes for participants:

- a) to live in the home of their choice.
- b) to work or engage in activities that contribute to the community.
- c) to have meaningful relationships; and
- d) to have good health. This OPWDD HCBS waiver amendment continues to build on this foundation to provide participants with a life that offers person-centered and individualized alternatives and to enable people to lead more typical lives in their communities. The HCBS waiver amendment continues to offer more choice, control and community membership through currently approved waiver services and service modifications.

Grievance & Complaints Policy

Grievance Procedure under the Americans with Disabilities Act This Grievance Procedure is established to meet the requirements of the Americans with Disabilities Act of 1990 ("ADA"). It may be used by anyone who wishes to file a complaint alleging discrimination based on disability in the provision of services, activities, programs, or benefits by the NYS Office for People with Developmental Disabilities (OPWDD). Employment-related complaints of disability discrimination are covered elsewhere, in policies available from the NYS Equal Employment Opportunity in New York State Rights & Responsibilities Handbook. The complaint should be in writing and contain information about the alleged discrimination such as name, address, phone number of complainant and location, date, and description of the problem. No particular format of the complaint is required. Alternative means of filing complaints, such as personal interviews or a tape recording of the complaint, will be made available for persons with disabilities upon request. The complaint should be submitted by the grievant and/or his or her designee as soon as possible but no later than 60 calendar days after the alleged violation to:

Dana K. Scalere ADDRESS: NYS Office for People with Developmental Disabilities 44 Holland Avenue Albany, NY 12229-0001

Within 15 calendar days after receipt of the complaint, the ADA Coordinator or his or her designee will meet with the complainant via telephone or in person to discuss the complaint and the possible resolutions. Within 15 calendar days of the meeting, the ADA Coordinator or his or her designee will respond in writing, and where appropriate, in a format accessible to the complainant, such as large print, Braille, or audio tape. The response will explain the position of the NYS Office of People with Developmental Disabilities and offer options for substantive resolution of the complaint. If the response by the ADA Coordinator or his or her designee does not satisfactorily resolve the issue, the complainant and/or his or her designee may appeal the decision within 15 calendar days after receipt of the response to the Commissioner of NYS OPWDD or her designee. Within 15 calendar days after receipt of the appeal, the Commissioner or his or her designee will respond in writing, and, where appropriate, in a format accessible to the complainant, with the agency's final resolution of the complaint, or indicating that the matter has been returned to the ADA Coordinator for further action.

If further action is indicated, the complainant will be contacted within 15 days from the written response. All written complaints received by the ADA Coordinator or his or her designee, appeals to the Commissioner or his or her designee, and responses from these two offices will be retained by the NYS office of People with Developmental Disabilities for at least three years.



The following persons and agencies are available to receive concerns and complaints from Individuals and their parent(s), guardian(s), or correspondents:

- Director, Staten Island DDRO
1150 Forest Hill Road
Staten Island NY 10314
(718) 983-5200

- Commissioner
NYS Office for People With Developmental Disabilities
44 Holland Avenue
Albany, NY 12229
(518) 473-1997

- State of N.Y. Mental Hygiene Legal Services (MHLS)
Staten Island Developmental Disabilities Regional Office (SIDDRO)
930 Willowbrook Road, Bldg. 15
Staten Island, NY 10314
(718) 979-3300

- NYS Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
Delmar, NY 12054-1310
(518) 549-0200



Individual Rights and Responsibilities Review and Signature Form

By signature below, I indicate that I have received and reviewed a copy of the Agency's revised Individual Rights and Responsibilities listing.

I have also received a list of persons and agencies available to receive concern and complaints, along with their addresses and telephone numbers.

I have also been informed of the Agencies 633 code by OPWDD, HCBS Wavier Services Rights, Grievance Policy, and Compliant Process.

Re:

Signature of Parent, Guardian or Correspondent

Date

Printed name of Parent, Guardian or Correspondent

***PLEASE submit the last page only of the individual rights for registration and keep all other pages for your records. ***



PROTECTION OF PEOPLE WITH SPECIAL NEEDS

If you would like to access the regulations pertaining to The Protections of People with Special Needs, please go to the Justice Center website: www.justicecenter.ny.gov

To report suspected abuse or neglect: 1-855-373-2122. For any questions call 1-800-624-4143.

If you have a problem accessing information, please contact either of the following:

Katherine Modena: 718-983-3800 EXT 225
Director of Program Services/Community Habilitation

Day Habilitation Administration:

Caroll Berliavsky: 718-983-3800 EXT 220

John Malczewski: 718 983 3800 EXT 229

Respite Administration:

Emily Shilleh: 718 983 3800 EXT 208
Manager of Respite Services

Selena Ramirez: 718 983 3800 EXT 206
Respite Administration

Kayla Le: 718 983 3800 EXT 230
Parent Coordinator

Signature

Print Name

Date



Dear GRACE Families:

Please note that we are always pleased to provide you with dependable and person-centered respite services.

The Respite Department strives to offer inclusive community respite outings accordingly, to benefit the individual in a person-centered manner while providing relief to the caregiver.

In keeping with personal allowance guidance of OPWDD, it is appropriate that an individual or his or her family use personal resources for admission/entrance fees for special respite activities or outings as part of the Respite service.

We will ensure that the expense supports the individual's community involvement and inclusion.

We will ensure that the individual willingly chooses to spend his/her money in this manner.

We will ensure that the individual directly benefits from the expenditure.

We will ensure that individual operating expenditures are not a routine/regular expenditure of the program.

Respite Services are provided in Site-Based, Recreational, and In-Home settings, and do not require payment.

Regarding community respite outings and trips, please note that any charge incurred is not for waiver services. Ancillary fees due to activities are completely optional, such as for food, souvenirs, or attractions. If you feel that your loved one would not enjoy an activity provided, please do not register them for the activity, as our goal is to be person-centered and supportive of their needs.

The HCBS Waiver does not allow charging individuals a "co-payment" for Waiver services or for establishing cost sharing arrangements, such as premiums or enrollment fees. In general, co-payment is an amount that is charged to the participant each time he/she receives a service. A cost sharing arrangement requires the individual to make a fixed, periodic payment to the provider which the GRACE Foundation does not require.

Signature _____

Print Name _____

Date _____



PS 55 Fitness Program for Non-Waiver Eligible Participants

If your son/daughter is NOT enrolling for our PS 55 gym program, you may skip this page!

Individual's Name: _____

Individual's Primary Language: _____

GRACE Personnel ONLY

Individual's Enrollment Date for PS 55 Gym: _____

How did you find out about our Fitness Program?

Parent Signature

Date



A Message to Our GRACE Families

Please know that the GRACE Foundation is dedicated to our mission to support our families. We want you to know that we are here to encourage and support. Going forward, we will continue to adhere to guidelines from OPWDD as they are mandated, regarding both restrictions and the possible changes in protocols and procedures. As with everything else, we look forward to offering extraordinary respite activities and opportunities throughout the year. Thank you for your trust in GRACE!

Together with teamwork!

If you have any further questions or concerns, please reach out to:
Katherine Modena, Director of Program Services.

Registrations can be emailed, faxed, or dropped off.

Email: KModena@GRACEofNY.org

Fax: (718) 351-3131

460 Brielle Avenue

Staten Island, NY

10314

INDIVIDUAL'S INFORMATION

Last Updated _____

| | | | |
|------------------------|-----------------|-----------------|---------------------|
| Name (Last, First, MI) | DOB | Residence Phone | Hospital Preference |
| Address | Medicaid ID | Medicare ID | Other Insurance |
| | Language Spoken | Communication | Legal Status |
| | Religion | | |

REASON FOR VISIT

To Be completed at time of transfer:

Pre-sedation given prior to leaving residence: Yes No

If YES to the above, names of medications:

Does the individual have a guardian? Yes No

If YES, provide name, relationship, and contact number:

CONSENT

Person(s) Authorized to Give Consent:

Individual

| | | |
|----------------------------|--------------|--|
| Name (First and Last) | Relationship | Telephone Numbers (h) (w) (c) |
| Address (City, State, Zip) | | |
| Name (First and Last) | Relationship | Telephone Numbers (h) (w) (c) |
| Address (City, State, Zip) | | |

ADVANCED DIRECTIVES

| | |
|---|------------------------------------|
| Non-Hospital DNR Order In Effect? Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> | Attach Copy of Order If Applicable |
| Health Care Proxy? Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> | Attach Copy of Order If Applicable |
| Other Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> | Attach Copy of Order If Applicable |
| If YES to Other, specify (i.e. MOLST, Living Will): | |

DIET AND CONSISTENCY

| |
|--|
| |
|--|

ALLERGIES

| |
|--|
| Medication Allergies (list with description of reaction if known): |
| Food Allergies (List) |
| Other (Latex, environmental, etc.) |

MEDICATIONS (See Attached Copy of Current Medication Administrative Record)

| |
|--|
| Routine medication given: _____ If Other, Specify: _____ |
|--|

INDIVIDUAL'S NAME:

Last Updated: _____

PRIMARY HEALTH CARE PROVIDER

| | | |
|------|----------------------------|--------|
| Name | Address (City, State, Zip) | Phone: |
| | | Fax: |

PHARMACY

| | | |
|------|----------------------------|--------|
| Name | Address (City, State, Zip) | Phone: |
| | | Fax: |

MEDICAL HISTORY

| |
|-------------------------|
| Diagnosis |
| Past Procedures/Surgery |

BASELINE

| | | | | | | | |
|---|---|---|---|----|----|----|---------|
| Vital Signs | T | P | R | BP | HT | WT | WT Date |
| Neurological/Mental Status (describe typical) | | | | | | | |
| Behavioral (PICA, etc.) | | | | | | | |

IMMUNIZATIONS (most recent)

| | | | | | |
|----------------|----------------|--------------------|--------------------|------------------|-------|
| Tetanus Date | Pneumovax Date | Influenza Date | Varicella Date | Varicella Status | Other |
| TB Status (mm) | PPD Date | Hepatitis B Status | Hepatitis C Status | | |

ADDITIONAL CONTACT INFORMATION

| | |
|-------------------------------------|--|
| Agency Name: Administrator/designee | Telephone Day Time: After Hours: |
| RN | Telephone Day Time: After Hours: |
| Service Coordinator | Telephone Day Time: After Hours: |
| Other Relationship | Telephone Day Time: After Hours: |

INDIVIDUAL'S NAME:

Last Updated: _____

ADDITIONAL INFORMATION

Other:

Print Name

Signature

Date