**THIS IS *NOT* AN APPLICATION FOR SERVICE AND DOES *NOT* GUARANTEE APPROVAL**

**Family Support Intake Form**

|  |  |
| --- | --- |
| Date |  |

|  |  |
| --- | --- |
| Name of Family Member with a Severe or DevelopmentalDisability |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Social Security # |  | Date of Birth |  |

|  |  |
| --- | --- |
| Name of Primary Family Member(s)  (if different than above) |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Family’s Address |  | Phone |  |
|  |  | Phone |  |
| County |  | Email Address |  |

Name of Emergency Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Referral to Family Support Services (include information on the impact of disability on family)

|  |
| --- |
|  |

Potential Support Services Needed/Requested (Check services needed):

|  |  |  |  |
| --- | --- | --- | --- |
| Before/After Care | Home Modifications | Specialized Equip. & Repair/Maintenance | Recreation/Summer Camp |
| Behavior Services | Home Maker Services | Specialized Nutrition/Cloth/  Supplies | Vehicle Modifications |
| Day Care | Nursing/Nurses  Aide | Training | Other: |
| Emergency Living Expenses | Personal Assistance | Transportation | Other: |
| Family Counseling | Respite | Health Related | Other: |

Is the Individual or Family Currently Receiving Other Services (Check all that apply)?

|  |  |  |  |
| --- | --- | --- | --- |
| Adoption Assistance | Medicaid | Residential Services | TennCare |
| CHOICES Waiver | Medicare | Social Security Income | Vocational Rehabilitation |
| DIDD Waivers | Nursing Services | Social Security Disability Income | PACE |
| Food Stamps | OPTIONS Program | Supported Living | Other: |
| Foster Care | Private Insurance | Tenn. Early Intervention System | Other: |

To comply with Title VI the following information is requested:

|  |  |  |  |
| --- | --- | --- | --- |
| Caucasian | African-American | Hispanic | Other |
| **Female** | **Male** |  |  |

TURN OVER

July 2015

**Family Support Intake Form, page 2**

If someone other than the family/individual is making a referral:

|  |  |
| --- | --- |
| Name of individual making referral to Family Support |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Agency |  | Phone |  |

|  |  |
| --- | --- |
| Address |  |

**Primary Disability** – Check which of the following major disability categories is most relevant to the family member with a severe disability as a primary diagnosis:

|  |  |
| --- | --- |
| Autism | Intellectual Disability |
| Cerebral Palsy | Neurological Impairment |
| Deaf and/or Blind | Orthopedic Impairment/ Physical Disability |
| Health Impairment | Spinal Cord Injury |
| Traumatic Brain Injury | Developmental Delay (Birth - 8 y.o.) |
| Other |  |

Is the applicant a United States citizen? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Did the person’s primary disability occur:**

|  |
| --- |
| Prior to age 22 |
| At age 22 or after |

By signing and dating this Intake Form, I the person supported or legal representative indicate that all of the information above is correct.

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Signature of Person Supported or Legal Representative |  | Date |

How was this information obtained?

NOTES

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| --- |
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|  |

January 2017