**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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|  |

January 2017