Department of Intellectual and Developmental Disabilities
Family Support Intake Form

Date: ______________________

Name of Family Member with a Severe or Developmental Disability: ______________________

Social Security #: ______________________ Date of Birth: ______________________

Name of Primary Family Member(s), if different than above:

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Family's Address: ______________________ Cell Phone: ______________________

______________________ Home Phone: ______________________

County of Residence: ______________________ E-mail: ______________________

Reason for referral to Family Support Program (include information on the impact of disability on the family)

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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	☐ ECF
☐ 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		

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

Name of individual making referral to Family Support:

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Agency: ______________________________________ Phone: ____________________

Address:

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

Did the person's primary disability occur:

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

By signing and dating this form, I, the person supported or legal representative, indicate that all of the information above is true and accurate. Furthermore, I understand providing invalid, inaccurate or incomplete information may result in denial of a claim, disenrollment from the program and/or criminal investigation. Disenrollment from the program would prevent reapplication in subsequent years.

____ ____________________

Signature of Person Supported or Legal Representative Date

How wasthis information obtained (i.e. face to face visit, by phone)?

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