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) _____

Family's Address _____ Phone _____

_____ Phone _____

County _____ Email 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

over

☐ **Female** ☐ **Male**

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
☐ 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 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 (ie. face to face visit, by phone)?

_____

NOTES

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