



Family Support Intake Form

THIS FORM MUST BE FILLED OUT IN ITS ENTIRETY

Date: _____ County of Residence: _____

Name of person with severe/developmental disability that Family Support is being applied for: _____

Social Security #: _____ - _____ - _____ Date of Birth: ____/____/____ Age: _____

Name of Parent/Spouse/Legal Representative, if different than above: _____

Family's Address: _____ E-mail: _____

Phone: _____ Phone: _____

Potential Support Services Needed/Requested (Check all that apply):

- Checkboxes for services: Before/After Care, Behavior Services, Daycare, Emergency Living Expenses, Family Counseling, Health Related, Homemaker Services, Home Modifications, Nursing/Nurse's Aide, Personal Assistance, Recreation/Summer Camp, Respite, Specialized Equipment & Maintenance/Repair, Specialized Nutrition/Clothing/Supplies, Training, Transportation, Vehicle Modifications, Other.

Do you (the person applying for Family Support) receive any of the following? (Check all that apply):

- Checkboxes for received services: Adoption Assistance, Food Stamps, Residential Services, Social Security Income, Social Security Disability Income, Foster Care, OPTIONS Program, Tennessee Early Intervention System (TEIS), PACE (Program of All-Inclusive Care for the Elderly), MAPs (Medicaid Alternative Pathway to Independence), Vocational Rehabilitation, Nursing Services, Supported Living, None.

What type of insurance do you (the person applying for Family Support) have?

- Checkboxes for insurance: TennCare (Medicaid), Medicare, Private Insurance, Uninsured.

Have you (the person applying for Family Support) applied for or do you receive any of the following? (Check all that apply):

- Checkboxes for programs: CHOICES, ECF Choices, DIDD Waivers, Katie Beckett Program, Any in home or community supports, None.

To comply with Title VI, the following information is being requested:

1. RACE (Check all that apply) [federal standards consider "Hispanic/Latino" to be an Ethnicity, to be answered below, separate from "Race"]:

- Checkboxes for race: American Indian/Alaskan Native, African American/Black, Caucasian/White, Hawaiian/Other Pacific Islander, Asian, Other.

2. ETHNICITY [if self-identified as "Hispanic/Latino," please answer the Race question separately above and then "Hispanic/Latino" here]:

- Checkboxes for ethnicity: Hispanic/Latino, Non-Hispanic/Latino.

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Primary Disability – Check which of the following “major disability categories” is most relevant to the person services are being requested for (as a primary diagnosis):

- | | |
|---|---|
| <input type="checkbox"/> Autism | <input type="checkbox"/> Intellectual Disability |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Neurological Impairment |
| <input type="checkbox"/> Blind | <input type="checkbox"/> Orthopedic Impairment/ Physical Disability |
| <input type="checkbox"/> Deaf | <input type="checkbox"/> Spinal Cord Injury |
| <input type="checkbox"/> Health Impairment | <input type="checkbox"/> Developmental Delay (Birth - 8 y.o.) |
| <input type="checkbox"/> Traumatic Brain Injury | <input type="checkbox"/> Down syndrome |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Genetic Disorders: (ex. Rett, Angelman, Trisomy 9, etc.)
Please specify _____ |

Did the person’s primary disability occur: Prior to age 22 At age 22 or after

NOTES: Please explain in detail how the Family Support funds would assist your family. Based on the diagnosis of the applicant, what needs is he/she unable to obtain without these supports? How would the applicant’s daily life be improved with this assistance? Use additional paper if necessary.

By signing and dating this Intake Form I, the person applying or their legal representative, indicate that all the information above is true and accurate. Furthermore, I understand that providing invalid, inaccurate, or incomplete information could be considered as fraud and may result in a criminal investigation and disqualification from the program which would prevent re-application in subsequent years.

Signature of Person Applying or Legal Representative _____

Date _____

How was this information obtained (i.e., face to face visit, by phone or mail)? _____

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

Name of person making referral to Family Support: _____

Agency: _____ Phone: _____

Address: _____