Family Support Intake Form

Date: ____________________________

2017-2018

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 (include information on the impact of disability on family)

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 yr.)
Other	

To comply with Title VI the following information is requested:

Caucasian African-American Hispanic Asian Other

Female Male

When did the person's primary disability occur?

Prior to age 22

At age 22 or after

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: ____________________

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Emergency Living Expenses	Personal Assistance	Transportation	Other: ____________
Family Counseling	Respite	Health Related	Other: ____________

What other service(s) does the applicant or family members receive? (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 Choices Waiver
Foster Care	Private Insurance	Tenn. Early Intervention System	Other: ____________

Is there any other information you would like for us to know at this time?

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Name of Person Completing Form: ____

Would you also like to sign up for a complimentary ARC membership for 2017-18? ☐ Yes ☐ No

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**

Return to:

The Arc Williamson County
129 West Fowlkes Street, Suite 151
Franklin, TN 37064
615-790-5815, ext. 3
615-790-5891 fax
sbbarc@thearcwc.org