

Family Support Intake Form



Date: _____

2018-2019

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 _____
County _____ Phone _____
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
- 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 yr.)

When did the person's primary disability occur?

- Prior to age 22
- At age 22 or after

To comply with Title VI the following information is requested:

- Caucasian
- African-American
- Hispanic
- Asian
- Other
- Female
- Male

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Potential Support Services Needed/Requested (Check services needed):

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Before/After Care | <input type="checkbox"/> Home Modifications | <input type="checkbox"/> Specialized Equip. & Repair/Maintenance | <input type="checkbox"/> Recreation/Summer Camp |
| <input type="checkbox"/> Behavior Services | <input type="checkbox"/> Home Maker Services | <input type="checkbox"/> Specialized Nutrition/Cloth/Supplies | <input type="checkbox"/> Vehicle Modifications |
| <input type="checkbox"/> Day Care | <input type="checkbox"/> Nursing/Nurses Aide | <input type="checkbox"/> Training | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Emergency Living Expenses | <input type="checkbox"/> Personal Assistance | <input type="checkbox"/> Transportation | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Family Counseling | <input type="checkbox"/> Respite | <input type="checkbox"/> Health Related | <input type="checkbox"/> Other: _____ |

What other service(s) does the applicant or family members receive? (Check all that apply):

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Adoption Assistance | <input type="checkbox"/> Medicaid | <input type="checkbox"/> Residential Services | <input type="checkbox"/> TennCare |
| <input type="checkbox"/> CHOICES Waiver | <input type="checkbox"/> Medicare | <input type="checkbox"/> Social Security Income | <input type="checkbox"/> Vocational Rehabilitation |
| <input type="checkbox"/> DIDD Waivers | <input type="checkbox"/> Nursing Services | <input type="checkbox"/> Social Security Disability Income | <input type="checkbox"/> PACE |
| <input type="checkbox"/> Food Stamps | <input type="checkbox"/> OPTIONS Program | <input type="checkbox"/> Supported Living | <input type="checkbox"/> ECF Choices Waiver |
| <input type="checkbox"/> Foster Care | <input type="checkbox"/> Private Insurance | <input type="checkbox"/> Tenn. Early Intervention System | <input type="checkbox"/> Other: _____ |

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

Name of Person Completing Form: _____

Would you also like to sign up for a complimentary ARC membership for 2018-19? 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**