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 of Residence: _____ E-mail: _____

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

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

_____

NOTES

_____

_____

_____

_____

_____

_____