



Family Support Intake Form

THIS FORM MUST BE FILLED OUT IN ITS ENTIRETY

Date: _____ County of Residence: _____

Name of person with severe/developmental disability applying for Family Support: _____

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

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):

- 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):

- Adoption Assistance, Food Stamps, Residential Services, Social Security Income, Social Security Disability Income, Foster Care, Tennessee Early Intervention System (TEIS), PACE (Program of All-Inclusive Care for the Elderly), OPTIONS Program, Vocational Rehabilitation, Nursing Services, Supported Living, None

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

- 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:

- atCHOICES, ECF Choices, DIDD Waivers, TBI Grant, Katie Beckett Program, Any in home or community supports, None

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

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

Family Support Intake Form, page 2

Primary Disability—Check which of the following major disability categories is most relevant to the person with a severe/development disability 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"/> Deaf and/or Blind | <input type="checkbox"/> Orthopedic Impairment/ Physical Disability |
| <input type="checkbox"/> Health Impairment | <input type="checkbox"/> Spinal Cord Injury |
| <input type="checkbox"/> Traumatic Brain Injury | <input type="checkbox"/> Developmental Delay (Birth - 8 years old) |
| | <input type="checkbox"/> Other |

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: _____