EMORY VALLEY CENTER
MAXIMIZING HUMAN ABILITIES

TN Department of Intellectual & Developmental Disabilities | Family Support Program

Department of Intellectual and Developmental Disabilities
2019-2020 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: ______________________

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County of Residence: ______________________ E-mail: ______________________________

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

- ☐ Before/After Care
- ☐ Behavior Services
- ☐ Daycare
- ☐ Emergency Living Expenses
- ☐ Family Counseling
- ☐ Home Modifications
- ☐ Home Maker Services
- ☐ Nursing/Nurses Aide
- ☐ Personal Assistance
- ☐ Respite
- ☐ Specialized Equip. & Maintenance Repair
- ☐ Specialized Nutrition/Clothing/ Supplies
- ☐ Training
- ☐ Transportation
- ☐ Health Related
- ☐ Recreation/Summer Camp
- ☐ Vehicle Modifications
- ☐ Other: ______________________
- ☐ Other: ______________________
- ☐ Other: ______________________

Is the Individual or Family Currently Receiving Other Services (Check all that apply)?

- ☐ Adoption Assistance
- ☐ CHOICES Waiver
- ☐ DIDD Waivers
- ☐ Food Stamps
- ☐ Foster Care
- ☐ Supported Living
- ☐ Medicaid
- ☐ Medicare
- ☐ Nursing Services
- ☐ OPTIONS Program
- ☐ Private Insurance
- ☐ Residential Services
- ☐ Social Security Income
- ☐ Social Security Disability Income
- ☐ Tenn. Early Intervention System
- ☐ TNCare
- ☐ Vocational Rehabilitation
- ☐ PACE
- ☐ ECF Choices
- ☐ TBI Grant
- ☐ Other ______________

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

☐ Caucasian ☐ African-American ☐ Hispanic ☐ Asian ☐ Other ☐ Unknown

☐ Female ☐ Male

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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 Intake Form, I, the person supported or legal representative, indicate that all of the information above is true and accurate. Furthermore, I understand that by providing invalid, inaccurate, or incomplete information could be considered as fraud and result in a criminal investigation, the denial of a claim, and/or disenrollment from the program which would prevent re-application 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 (Please explain in detail why you need financial assistance from the Family Support program**):**

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