

2021-2022 Family Support Intake Form

Fill out this intake **completely** and return with all required documents (see attached letter). Your intake will only be reviewed if **ALL** sections are completed and **ALL** required proofs have been received.

Date: _____

County of Residence: _____

Name of the person Family Support services are being requested for: _____

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):

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Before/After Care | <input type="checkbox"/> Health Related | <input type="checkbox"/> Recreation/Summer Camp | <input type="checkbox"/> Training |
| <input type="checkbox"/> Behavior Services | <input type="checkbox"/> Homemaker Services | <input type="checkbox"/> Respite | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Daycare | <input type="checkbox"/> Home Modifications | <input type="checkbox"/> Specialized Equipment & Maintenance/Repair | <input type="checkbox"/> Vehicle Modifications |
| <input type="checkbox"/> Emergency Living Expenses | <input type="checkbox"/> Nursing/Nurse's Aide | <input type="checkbox"/> Specialized Nutrition/Clothing/Supplies | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Family Counseling | <input type="checkbox"/> Personal Assistance | | |

Do you (the person services are being requested for) receive any of the following? (Check all that apply):

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Adoption Assistance | <input type="checkbox"/> Social Security Income | <input type="checkbox"/> TEIS (Tennessee Early Intervention System) | <input type="checkbox"/> Vocational Rehabilitation |
| <input type="checkbox"/> Food Stamps | <input type="checkbox"/> Social Security Disability Income | <input type="checkbox"/> PACE (Program of All-Inclusive Care for the Elderly) | <input type="checkbox"/> Nursing Services |
| <input type="checkbox"/> Residential Services | <input type="checkbox"/> Foster Care | <input type="checkbox"/> OPTIONS Program | <input type="checkbox"/> Supported Living |
| | | | <input type="checkbox"/> None |

What type of insurance do you (the person services are being requested for) have?

- TennCare (Medicaid) Medicare Private Insurance Uninsured

Have you (the person services are being requested for) applied for or do you receive any of the following? (Check all that apply):

- CHOICES 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 (please check all that apply):

- African-American MALE
 Asian FEMALE
 Caucasian
 Hispanic
 Other
 Unknown

| | | |
|--|--|--|
| FOR AGENCY USE ONLY | | |
| <input type="checkbox"/> Intake logged | <input type="checkbox"/> POD rec'd | <input type="checkbox"/> Sign 4 sent |
| <input type="checkbox"/> POR rec'd | <input type="checkbox"/> EC & Priority # | <input type="checkbox"/> Sign 4 rec'd |
| <input type="checkbox"/> POC rec'd | <input type="checkbox"/> Intake scanned | <input type="checkbox"/> Invoices sent |

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Primary Disability – Check which of the following major disability categories is most relevant to the person services are being requested for (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 y.o.) |
| | <input type="checkbox"/> Other |

Did the person’s primary disability occur: Prior to age 22 At age 22 or after

NOTES: In order for us to understand your needs more clearly, 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.

Please do not leave any sections blank, as your intake will not be reviewed unless it is complete.

By signing and dating this Intake Form I, the person applying or their legal representative, indicate that all of 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 services are being requested for or Legal Representative Date

If someone other than the family/person is making a referral

Name of person making referral to Family Support: _____

Agency: _____ Phone: _____

Address: _____

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Please describe the current living situation of the person services are being requested for. Who does he/she live with?

Are there other individuals with disabilities residing in the home? **YES** or **NO**

If **YES**, please describe the relationship to the applicant and the nature of their disability. _____

Please describe how the applicant's disability affects his/her daily life and his/her family's life.

Does the applicant attend any regular appointments (physician, therapies, etc.) If so, please explain.

Applicant's Self Care & Daily Living Skills

Applicants age: _____

| Please check the applicable box for each activity of daily living | Needs Total Assistance | Needs Some Assistance | Needs No Assistance | Please Describe the Assistance needed/provided <i>DO NOT LEAVE BLANK</i> |
|---|------------------------|-----------------------|---------------------|--|
| Eating (Does not include meal prep) | | | | |
| Dressing | | | | |
| Bathing | | | | |
| Toileting | | | | |
| Transfers in/out of bed/wheelchair/shower/toilet | | | | |
| Preparing meals | | | | |
| Making medical appointments | | | | |
| Shopping for groceries, taking medications | | | | |
| Completing household chores | | | | |
| Managing money | | | | |

Applicant's ability to Communicate

Is the applicant's ability to communicate affected by their disability? **YES** or **NO**

How does the applicant prefer to communicate with others (speaking, assistive device, sign, etc.)?

And can others easily understand them?

Does the applicant have difficulty understanding verbal instructions/conversations? **YES or NO**

Applicant's ability to Learn

Is the applicant's ability to learn affected by their disability? **YES or NO**

If yes, please describe how learning is affected: _____

Applicant's Mobility (ability to walk, move around in their home and in the community, manage stairs or uneven terrain)

Is the applicant's mobility affected by their disability? **YES or NO**

If YES, how is his/her mobility affected? _____

Does the applicant require a supportive device (walker, cane, wheelchair, etc.)? **YES or NO**

If YES, please describe what supportive device is needed: _____

Applicant's Self Direction

Is the applicant aware of danger (crossing the street, hot water/stove, stranger danger)? **YES or NO**

Does the applicant have behavioral or stemming issues? **YES or NO**

Is the applicant able to tell and manage time? **YES or NO**

How does the applicant's disability affect his/her judgement and ability to make decisions? _____

Does the applicant need *constant* supervision due to safety concerns? **YES or NO**

Applicant's Economic Self-Sufficiency

Is the applicant employed? **YES or NO**

Are accommodations made so that he/she can work (altered schedule, escort, etc.) **YES or NO**

If YES, please describe those accommodations: _____

How does the applicant's disability affect his/her ability to work? _____
