EMORY VALLEY CENTER
MAXIMIZING HUMAN ABILITIES

TN Department of Intellectual & Developmental Disabilities | Family Support Program

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):

- ☐ 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 services are being requested for) receive any of the following? (Check all that apply):

- ☐ Adoption Assistance
- ☐ Food Stamps
- ☐ Residential Services
- ☐ Social Security Income
- ☐ Social Security Disability Income
- ☐ Foster Care
- ☐ TEIS (Tennessee Early Intervention System)
- ☐ 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 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
- ☐ Asian
- ☐ Caucasian
- ☐ Hispanic
- ☐ Other
- ☐ Unknown
- ☐ MALE
- ☐ FEMALE

FOR AGENCY USE ONLY

- ☐ Intake logged
- ☐ POR rec'd
- ☐ POC rec'd
- ☐ POD rec'd
- ☐ EC & Priority #
- ☐ Intake scanned
- ☐ Sign 4 sent
- ☐ Sign 4 rec'd
- ☐ 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):

- ☐ Autism
- ☐ Cerebral Palsy
- ☐ Deaf and/or Blind
- ☐ Health Impairment
- ☐ Traumatic Brain Injury
- ☐ Intellectual Disability
- ☐ Neurological Impairment
- ☐ Orthopedic Impairment/ Physical Disability
- ☐ Spinal Cord Injury
- ☐ Developmental Delay (Birth - 8 y.o.)
- ☐ 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 *DO NOT LEAVE BLANK***
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? _____

_____

_____