

## Family Support 2025 – 2026 Intake

The Tennessee Family Support Program is a grant program, totally funded with state dollars and administered through the Tennessee Department of Disability and Aging (TDDA). This program offers a small amount of financial support to help people (of all ages) **with a severe lifelong disability**, and their families to remain together in their homes and communities, while living as independently as possible. These services are flexible and responsive to the families and their needs.

**\*PLEASE NOTE\*** Individuals who are enrolled in the Katie Beckett Waiver, ECF Choices, DIDD Waiver, TennCare Choices or Pace programs are **NOT** eligible for the Family Support grant.

**\*\*Please also note that our email has changed to [Family.Support@evcmail.org](mailto:Family.Support@evcmail.org)**

The 25 – 26 fiscal year runs from July 1, 2025 – June 30, 2026.

- Due to limited funding, it is possible that some applicants who are considered eligible will not receive a grant for the 25-26 fiscal year.
- Applicants are not guaranteed to be awarded a grant, even if they have received one in previous years.
- If the applicant is approved to receive a grant, the amount is not guaranteed to be the same amount it was in previous years.
- Selection must be open to every person applying each year, as if they have never applied before.
- Selection is based on priorities set by the local council, and applications are ranked according to these priorities.
- We strive to notify families of their application status as quickly as possible. Our guidelines, which are set by the state, declare we must notify applicants of their application status no later than Sept. 30<sup>th</sup>. (If you apply after this date, we'll notify you of your application status asap).

### **Incomplete applications will not be reviewed.**

Applications are not reviewed until all REQUIRED DOCUMENTS have been received in our office. Please see the next page for this list.

Assistance with Spanish interpretation is available.

Please let us know if you have any questions.

Sincerely,

Regina Wilson, Family Support Director

Family Support Program, Emory Valley Center

To apply for the 2025 – 2026 Family Support grant, you must submit the attached form (4 pages total) **and all of these required documents:**

- Proof of Disability** Clearly stated diagnosis list from a physician. For school age children with an IEP – please also provide a copy of their most recent, full IEP. For young children enrolled in TEIS – please also provide their most recent IFSP.
- Proof of Residency** Current utility bill (water, gas, electric or internet) that shows the service address – we need this for the address on the intake form, even if the services are not in your name.
- Proof of Citizenship** Copy of legal birth certificate OR proof of qualified alien status/current USCIS documentation. (We cannot accept the hospital souvenir or the mother’s copy). *If the applicant has received the grant in previous years, we may have this on file.*
- Social Security Card** *If the applicant has received the grant in previous years, we may have this on file.*
- Proof of Custody** If the applicant is not your biological child, or if the child was adopted. (If the child was adopted, all documents must be consistent with their adopted name on them). *If the applicant has received the grant in previous years, we may have this on file.*
- Conservatorship** If one is already in place. (Applicants 18 years or older are responsible for signing for themselves unless legal documentation is provided giving consent to someone else). *If the applicant has received the grant in previous years, we may have this on file.*

These documents may be returned by mail, email, fax, or hand delivered to our office. Please do not send them as screenshots taken from your phone.

**Mail:**

Attn: Family Support  
723 Emory Valley Rd.  
Oak Ridge, TN 37830

**Email:**

[Family.Support@evcmail.org](mailto:Family.Support@evcmail.org)

**Fax:**

(865) 813-0579  
(865) 813-0577  
(865) 813-0578

**IMPORTANT!!!** We log intakes into our system in the order we receive them. Once your intake and all required documents are received and logged in, we’ll send an email (or a letter if you don’t have an email) letting you know everything has been received, and when you can expect to receive status of your grant application.

Shared Email: [Family.Support@evcmail.org](mailto:Family.Support@evcmail.org)

Regina Wilson – Family Support Director – Phone/Text/Fax: (865) 813-0578 - [Regina.Wilson@evcmail.org](mailto:Regina.Wilson@evcmail.org)

Britney Richardson – Family Support Manager – Phone/Text/Fax: (865) 813-0579 - [Britney.Richardson@evcmail.org](mailto:Britney.Richardson@evcmail.org)

Daniel Vargas – Family Support Assistant, Bilingual – Phone/Text/Fax: (865) 813-0577 - [Daniel.Vargas-Raidi@evcmail.org](mailto:Daniel.Vargas-Raidi@evcmail.org)

Leah Myers - Family Support Assistant - Phone/Text/Fax: (865) 813-0570 - [Leah.Myers@evcmail.org](mailto:Leah.Myers@evcmail.org)

## 2025 – 2026 Family Support Intake Form

Date: \_\_\_\_\_

County: \_\_\_\_\_

What is your name? \_\_\_\_\_ Are you applying for yourself? \_\_\_ Yes \_\_\_ No

Name of the person you're applying for: \_\_\_\_\_ Your relationship to them: \_\_\_\_\_

### INFORMATION GOING FORWARD SHOULD BE ABOUT THE PERSON YOU ARE APPLYING FOR

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_ Age: \_\_\_\_\_

Family's Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

\_\_\_\_\_ Email: \_\_\_\_\_

Do you rent or own your home? \_\_\_ Rent \_\_\_ Own *(Communication from Family Support will come to this email)*

What language do you prefer to use when communicating with Family Support? \_\_\_\_\_

#### 1. Potential Support Services Needed/Requested (Check all that apply):

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

#### 2. Do you (the person you're applying for) receive any of the following? (Check all that apply):

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Adoption Assistance                                 | <input type="checkbox"/> Nursing Services                                     | <input type="checkbox"/> Residential Services      | <input type="checkbox"/> Supported Living                    |
| <input type="checkbox"/> Food stamps (SNAP)                                  | <input type="checkbox"/> OPTIONS Program                                      | <input type="checkbox"/> Social Security Income    | <input type="checkbox"/> TEIS (TN Early Intervention System) |
| <input type="checkbox"/> Foster Care   | <input type="checkbox"/> PACE (Program of All-Inclusive Care for the Elderly) | <input type="checkbox"/> Vocational Rehabilitation |  |
| <input type="checkbox"/> MAPs (Medicaid Alternative Pathway to Independence) | <input type="checkbox"/> SSI Disability Income                                | <input type="checkbox"/> NONE OF THESE             |  |

#### 3. What type of insurance do you (the person you're applying for) have? (Check all that apply):

- |  |                                   |  |                                    |
|--|-----------------------------------|--|------------------------------------|
| <input type="checkbox"/> TennCare (Medicaid) | <input type="checkbox"/> Medicare | <input type="checkbox"/> Private Insurance | <input type="checkbox"/> Uninsured |
|--|-----------------------------------|--|------------------------------------|

#### 4. Do you (the person you're applying for) currently receive any of the following? (Check all that apply)

- |                                  |                                      |                                       |   |  |
|----------------------------------|--------------------------------------|---------------------------------------|---|--|
| <input type="checkbox"/> CHOICES | <input type="checkbox"/> ECF Choices | <input type="checkbox"/> DIDD Waivers | <input type="checkbox"/> Katie Beckett Waiver | <input type="checkbox"/> NONE OF THESE |
|----------------------------------|--------------------------------------|---------------------------------------|---|--|

#### 5. Have you (the person you're applying for) applied for any of the following? (Check all that apply)

- |                                  |                                      |   |  |
|----------------------------------|--------------------------------------|---|--|
| <input type="checkbox"/> CHOICES | <input type="checkbox"/> ECF Choices | <input type="checkbox"/> Katie Beckett Waiver | <input type="checkbox"/> NONE OF THESE |
|----------------------------------|--------------------------------------|---|--|

**To comply with Title VI, the following information is being requested (Check all that apply):**

1. GENDER: MALE  FEMALE

2. RACE:  African American/Black  Caucasian/White  Middle Eastern/North African  
 American Indian/Alaskan Native  Hawaiian/Other Pacific Islander  Other/Not Listed  
 Asian  Hispanic/Latino

**DIAGNOSED DISABILITY - Check which of the following “major disability categories” is most relevant to the applicant’s diagnosed condition(s). You must provide proof for each diagnosed disability that’s checked:**

- Autism  Down syndrome  Neurological Impairment  Spinal Cord Injury
- Blind  Genetic Disorder (Ex: Rett, Angelman, Trisomy 9, etc.)  Traumatic Brain Injury
- Cerebral Palsy  Health Impairment (Please specify): \_\_\_\_\_  Other: \_\_\_\_\_
- Deaf  Intellectual Disability  Orthopedic Impairment/Physical Disability
- Developmental Delay (5 years old and younger only)

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

**IF AWARDED GRANT MONEY, WHAT ARE YOU HOPING TO SPEND IT ON? DO NOT LEAVE THIS BLANK.**

(Due to the applicant’s diagnosis, what is needed, or would be beneficial to improve his/her life? Please list below, in order of importance, what items/services you want to use the funds for and the approximate cost.)

---



---



---



---



---



---

**By signing and dating this intake form, I, the person applying for the Family Support grant, OR their legal representative, indicate that all information provided 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 Applicant or their Legal Representative** (Any person 18 or older must sign for themselves unless legal documentation is provided giving consent to someone else)

**Date**

**If someone other than the family/applicant is making a referral:**

Name of referring person: \_\_\_\_\_ Referring Agency: \_\_\_\_\_

Phone number: \_\_\_\_\_ Email address: \_\_\_\_\_

**Family Support 2025 – 2026 Intake Form – continued**

1. Please describe the current living situation of the person the grant is being requested for. Who does he/she live with? List everyone living under the same roof. \_\_\_\_\_  
\_\_\_\_\_

2. Please describe how the applicant’s disability affects/impacts his/her daily life and his/her family’s life.  
\_\_\_\_\_  
\_\_\_\_\_

3. Are there other individuals with disabilities residing in the home? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, who has the disability and what is it? \_\_\_\_\_

4. Does the applicant attend any regular medical appointments (physician, specialist, therapies, etc.)? If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_

5. Is the applicant’s ability to communicate affected by their disability? Yes \_\_\_\_\_ No \_\_\_\_\_

6. How does the applicant prefer to communicate with others (speaking, assistive device, signs, gestures, etc.)? \_\_\_\_\_

7. Are others able to understand the applicant? \_\_\_\_\_

8. Does the applicant have difficulty understanding verbal instructions? Yes \_\_\_\_\_ No \_\_\_\_\_

9. Does the applicant have difficulty following along in conversations? Yes \_\_\_\_\_ No \_\_\_\_\_

10. Is the applicant’s mobility affected by their disability? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please explain how their mobility is affected by their disability: \_\_\_\_\_  
\_\_\_\_\_

11. If 3 years or older, does he/she use a supportive device (walker, cane, wheelchair, brace, etc.)? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please describe what device is used to assist with mobility: \_\_\_\_\_  
\_\_\_\_\_

12. Does the applicant have behavior or stimming issues due to their diagnosis?

Yes \_\_\_\_\_ No \_\_\_\_\_ N/A \_\_\_\_\_ If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_

13. Does the applicant need CONSTANT supervision, due to safety concerns that are related to their disability (NOT due to his/her age)? Yes \_\_\_\_\_ No \_\_\_\_\_

The next few pages are for the age of the person applying. You only need to fill out one more page with questions. Look at pages 4 to 8 to find the page that matches the age of the person you're applying for, and skip the other four. You'll see the age category at the top of each page.

For applicants age **infant to 5 years** old, please answer the following questions:

1. Does he/she drink from a: Bottle \_\_\_\_ Sippy Cup \_\_\_\_ Cup with straw \_\_\_\_  
Open cup with help \_\_\_\_ Open cup with no help \_\_\_\_
2. Does he/she feed themselves? Yes \_\_\_\_ No \_\_\_\_ Feeding tube \_\_\_\_
3. Can he/she use utensils? Yes \_\_\_\_ No \_\_\_\_ N/A \_\_\_\_
4. Does he/she have food aversions? Yes \_\_\_\_ No \_\_\_\_ If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_
5. Does he/she have food allergies? Yes \_\_\_\_ No \_\_\_\_ If yes, please list: \_\_\_\_\_
6. Does he/she have choking concerns? Yes \_\_\_\_ No \_\_\_\_
7. Does he/she try to help with getting dressed and undressed? Yes \_\_\_\_ No \_\_\_\_ N/A \_\_\_\_
8. Does he/she have any sensitivity to clothing (certain fabrics, textures, etc.)?  
Yes \_\_\_\_ No \_\_\_\_ If yes, please explain: \_\_\_\_\_
9. Does he/she need any help with zippers, buttons, tying shoes or similar dressing tasks? If yes, please explain: \_\_\_\_\_
10. Is there any sensitivity to face washing, hair washing, etc.? \_\_\_\_\_
11. If 3 years or older, does he/she still wear diapers/pull-ups? Yes \_\_\_\_ No \_\_\_\_ N/A \_\_\_\_
12. If 3 years old or older, is he/she potty trained? Yes \_\_\_\_ No \_\_\_\_ We're working on it \_\_\_\_  
N/A \_\_\_\_
13. Is he/she able to do simple step tasks, as age appropriate (throw a tissue in the trash, put a toy in the closet, etc. if asked)? Yes \_\_\_\_ No \_\_\_\_ N/A \_\_\_\_
14. Does he/she enjoy interacting with people? Most of the time \_\_\_\_ Only with familiar faces \_\_\_\_  
Not at all \_\_\_\_ Unpredictable \_\_\_\_
15. As a caregiver for this child, what additional things do you do each day because of their disability, that you wouldn't have to do otherwise? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

For applicants age 6 years to 13 years old, please answer the following questions:

1. Does he/she feed themselves? Yes \_\_\_\_ No \_\_\_\_ Feeding tube \_\_\_\_
2. Does he/she need their food prepared in a particular way? Blended \_\_\_\_ Finely chopped \_\_\_\_  
Thickened \_\_\_\_ N/A \_\_\_\_
3. Does he/she have food aversions? Yes \_\_\_\_ No \_\_\_\_ If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_
4. Does he/she have food allergies? Yes \_\_\_\_ No \_\_\_\_ If yes, please list: \_\_\_\_\_
5. Does he/she have choking concerns? Yes \_\_\_\_ No \_\_\_\_
6. Can he/she open food items on their own (packages, drink tops, etc.)? Yes \_\_\_\_ No \_\_\_\_
7. If age appropriate, does he/she cook food in the microwave? Yes \_\_\_\_ No \_\_\_\_ N/A \_\_\_\_
8. Does he/she bathe on their own? Yes \_\_\_\_ No \_\_\_\_ If No, what assistance is needed for the applicant to bathe (check all that apply)? Physical assistance \_\_\_\_ Reminders \_\_\_\_  
Prompting throughout \_\_\_\_ N/A \_\_\_\_
9. Does he/she use the toilet on their own? Yes, totally \_\_\_\_ Needs some assistance \_\_\_\_  
Needs full assistance \_\_\_\_ Wears briefs \_\_\_\_ Medical equipment used (catheter, etc.) \_\_\_\_
10. Is he/she able to dress/undress themselves (check all that apply)? Yes, with no assistance \_\_\_\_  
Needs physical assistance \_\_\_\_ Needs prompting throughout the task \_\_\_\_
11. Does he/she have any sensitivity to clothing (certain fabrics, textures, etc.)?  
Yes \_\_\_\_ No \_\_\_\_ If yes, please list: \_\_\_\_\_
12. Does he/she need any help with zippers, buttons, tying shoes or similar dressing tasks? If yes, please explain: \_\_\_\_\_
13. Does he/she need assistance to do age-appropriate chores around the home? (Check all that apply):  
Needs no help \_\_\_\_ Needs reminders \_\_\_\_ Needs prompting throughout the task \_\_\_\_  
Needs physical assistance \_\_\_\_ Explain: \_\_\_\_\_
14. Is he/she able to tell the time? Yes \_\_\_\_ No \_\_\_\_ N/A \_\_\_\_
15. Can he/she manage time or know routines? Yes \_\_\_\_ No \_\_\_\_
16. Would he/she be able to call 911, self-evacuate in an emergency: Yes \_\_\_\_ No \_\_\_\_ Unsure \_\_\_\_
17. Can he/she count and understand the value of money? Yes \_\_\_\_ No \_\_\_\_ Working on it \_\_\_\_
18. Does he/she need **constant** supervision due to safety concerns related to their diagnosed disability?  
Yes \_\_\_\_ No \_\_\_\_

For applicants age 14 years to high school graduating age, please answer the following questions:

1. Does he/she feed themselves? Yes \_\_\_\_ No \_\_\_\_ Feeding tube \_\_\_\_
2. Does he/she need their food prepared in a particular way? Blended \_\_\_\_ Finely chopped \_\_\_\_  
Thickened \_\_\_\_ N/A \_\_\_\_
3. Does he/she have food aversions? Yes \_\_\_\_ No \_\_\_\_ If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_
4. Does he/she have food allergies? Yes \_\_\_\_ No \_\_\_\_ If yes, please list: \_\_\_\_\_
5. Does he/she have choking concerns? Yes \_\_\_\_ No \_\_\_\_
6. Can he/she open food items on their own (packages, drink tops, etc.)? Yes \_\_\_\_ No \_\_\_\_
7. Does he/she cook food using the stove or microwave? Yes \_\_\_\_ No \_\_\_\_
8. Does he/she bathe on their own? Yes \_\_\_\_ No \_\_\_\_ If No, what assistance is needed for the applicant to bathe (check all that apply)? Physical assistance \_\_\_\_ Reminders \_\_\_\_  
Prompting throughout \_\_\_\_ N/A \_\_\_\_
9. Does he/she toilet on their own? Yes, totally \_\_\_\_ Needs some assistance \_\_\_\_  
Needs full assistance \_\_\_\_ Wears briefs \_\_\_\_ Medical equipment used (catheter, etc.) \_\_\_\_
10. Is he/she able to dress/undress themselves (check all that apply)? Yes, with no assistance \_\_\_\_  
Needs physical assistance \_\_\_\_ Needs prompting throughout the task \_\_\_\_
11. Does he/she have any sensitivity to clothing (certain fabrics, textures, etc.)? Yes \_\_\_\_ No \_\_\_\_  
If yes, please list: \_\_\_\_\_
12. Does he/she need any help with zippers, buttons, tying shoes or similar dressing tasks? If yes, please explain: \_\_\_\_\_
13. Does he/she need assistance to do age-appropriate chores around the home? (Check all that apply):  
Needs no help \_\_\_\_ Needs reminders \_\_\_\_ Needs prompting throughout the task \_\_\_\_  
Needs physical assistance \_\_\_\_ Other \_\_\_\_ If Other, please explain: \_\_\_\_\_
14. Is he/she able to tell the time? Yes \_\_\_\_ No \_\_\_\_
15. Can he/she manage time or know routines? Yes \_\_\_\_ No \_\_\_\_
16. Would he/she be able to call 911, self-evacuate in an emergency: Yes \_\_\_\_ No \_\_\_\_ Unsure \_\_\_\_
17. Can he/she count/manage/understand the value of money? Yes \_\_\_\_ No \_\_\_\_ Working on it \_\_\_\_
18. Does he/she need **constant** supervision due to safety concerns? Yes \_\_\_\_ No \_\_\_\_
19. If 16 or older, does he/she have a job? Yes \_\_\_\_ No \_\_\_\_ N/A \_\_\_\_ What accommodations have been/would need to be put in place, if any so they can work (adjusted schedule, specific task, etc.) \_\_\_\_\_

For applicants that have aged out of high school and are younger than 65, please answer the following questions:

1. Does he/she feed themselves? Yes  No  Feeding tube
2. Does he/she need their food prepared in a particular way? Blended  Finely chopped   
Thickened  N/A
3. Does he/she have food aversions? Yes  No  If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_
4. Does he/she have food allergies? Yes  No  If yes, please list: \_\_\_\_\_
5. Does he/she have choking concerns? Yes  No
6. Can he/she open food items on their own (packages, drink tops, etc.)? Yes  No
7. Does he/she cook food using the microwave/oven/stove? Yes  No
8. Does he/she bathe on their own? Yes  No  If No, what assistance is needed for the applicant to bathe (check all that apply)? Physical assistance  Reminders  Prompting throughout
9. Does he/she toilet on their own? Yes, totally  Needs some assistance   
Needs full assistance  Wears briefs  Medical equipment used (catheter, etc.)
10. Is he/she able to dress/undress themselves (check all that apply)? Yes, with no assistance   
Needs physical assistance  Needs prompting throughout the task
11. Does he/she have any sensitivity to clothing (certain fabrics, textures, etc.)?  
Yes  No  If yes, please list: \_\_\_\_\_
12. Does he/she need any help with zippers, buttons, tying shoes or similar dressing tasks? If yes, please explain:  
\_\_\_\_\_
13. Does he/she need assistance to do chores around the home? (Check all that apply):  
Needs no help  Needs reminders  Needs prompting throughout the task   
Needs physical assistance  Other  If Other, please explain: \_\_\_\_\_
14. Is he/she able to tell the time? Yes  No
15. Can he/she manage time or know routines? Yes  No
16. Would he/she be able to call 911, self-evacuate in an emergency: Yes  No  Unsure
17. Can he/she count/manage/understand the value of money? Yes  No  Working on it
18. Does he/she need **constant** supervision due to safety concerns? Yes  No
19. Does he/she have a job? Yes  No  What accommodations have been/or would need to be put in place, if any so they can work (adjusted schedule, specific task, etc.) \_\_\_\_\_  
\_\_\_\_\_

For applicants **65 and older**, please answer the following questions:

1. Does he/she feed themselves? Yes  No  Feeding tube
2. Does he/she need their food prepared in a particular way? Blended  Finely chopped   
Thickened  N/A
3. Does he/she have food aversions? Yes  No  If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_
4. Does he/she have food allergies? Yes  No  If yes, please list \_\_\_\_\_
5. Does he/she have choking concerns? Yes  No
6. Can he/she open food items on their own (packages, drink tops, etc.)? Yes  No
7. Does he/she cook food using the microwave/oven/stove? Yes  No
8. Does he/she bathe on their own? Yes  No  If No, what assistance is needed for the applicant to bathe (check all that apply)? Physical assistance  Reminders   
Prompting throughout the task
9. Does he/she toilet on their own? Yes, totally  Needs some assistance   
Needs full assistance  Wears briefs  Medical equipment used (catheter, etc.)
10. Is he/she able to dress/undress themselves (check all that apply)? Yes, with no assistance   
Needs physical assistance  Needs prompting  Needs clothes selected
11. Does he/she have any sensitivity to clothing (certain fabrics, textures, etc.)?  
Yes  No  If yes, please list: \_\_\_\_\_
12. Does he/she need any help with zippers, buttons, tying shoes or similar dressing tasks? If yes, please explain: \_\_\_\_\_
13. Does he/she need assistance to do chores around the home? (Check all that apply):  
Needs no help  Needs reminders  Needs prompting throughout the task   
Needs physical assistance  Other  If Other, please explain: \_\_\_\_\_
14. Is he/she able to tell the time? Yes  No
15. Can he/she manage time or know routines? Yes  No
16. Would he/she be able to call 911, self-evacuate in an emergency: Yes  No  Unsure
17. Can he/she count/manage/understand the value of money? Yes  No
18. Does he/she need **constant** supervision due to safety concerns? Yes  No
19. Does he/she have a job? Yes  No  Retired  What accommodations are/were/or would need to be put in place, if any so they can work (adjusted schedule, specific task, etc.)  
\_\_\_\_\_