TN Department of Intellectual & Developmental Disabilities | Family Support Program

Family Support Intake Form

THIS FORM MUST BE FILLED OUT IN ITS ENTIRETY

Date: _____ County of Residence: _____

Name of person with severe/developmental disability that Family Support is being applied for: _____

Social Security #: _____-_____-_____ Date of Birth: _____/_____/_____ Age: _____

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
- ☐ OPTIONS Program
- ☐ Tennessee Early Intervention System(TEIS)
- ☐ PACE (Program of All-InclusiveCare for the Elderly)
- ☐ MAPs (Medicaid Alternative Pathway to Independence)
- ☐ 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):

☐ CHOICES ☐ ECF Choices ☐ DIDD Waivers ☐ Katie Beckett Program ☐ Any in home or community supports

☐ None

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

1. RACE (Check all that apply) [federal standards consider "Hispanic/Latino" to be an Ethnicity, to be answered below, separate from "Race"]:

☐ American Indian/Alaskan Native ☐ African American/Black ☐ Caucasian/White ☐ Hawaiian/Other Pacific Islander ☐ Asian ☐ Other

2. ETHNICITY [if self-identified as "Hispanic/Latino," please answer the Race question separately above and then "Hispanic/Latino" here]:

☐ Hispanic/Latino ☐ Non-Hispanic/Latino

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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
- ☐ Blind
- ☐ Deaf
- ☐ Health Impairment
- ☐ Traumatic Brain Injury
- ☐ Other _____
- ☐ Intellectual Disability
- ☐ Neurological Impairment
- ☐ Orthopedic Impairment/ Physical Disability
- ☐ Spinal Cord Injury
- ☐ Developmental Delay (Birth - 8 y.o.)
- ☐ Down syndrome
- ☐ Genetic Disorders: (ex. Rett, Angelman, Trisomy 9, etc.) Please specify_____

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: _____

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Washington County

Family Support Application

Name of family member with disability_____Date of Birth _____

Please describe limitations in each category as it relates to the person with the disability. If assistance is needed, please describe limitations or what assistance is needed for each category. Assistance can include regular prompting, special equipment, or total assistance from another individual. Give specifics.

1. **Self-Care** (dressing/feeding/eating/toilet/personal hygiene)

_____
_____
_____

2. **Communication** expressive language vocalizing slash communicating to others and receptive language (understanding information from others)

_____
_____
_____

3. **Learning** (support and/or devices needed in an educational setting)

_____
_____
_____

4. **Mobility** (ability to move around and/or use one's physical abilities)

_____
_____
_____

5. **Self-Direction** (ability to judge common sense, make reasonable decisions, control emotions, and understand danger)

_____
_____
_____

6. **Capability for independent living** (Shopping, cooking, traveling about, money, time management)

_____
_____
_____

The Arc
Washington County

7. **Economic self-sufficiency** (ability to obtain and retain a job in a competitive work force)

_____
_____
_____

United Way Helps Here

Please share more information about the services you are requesting.

Respite: How often is it needed? _____

Does the caretaker need the respite so they can work? Yes [] No []

Home modification (modification to make home safer for the person with the disability) Yes [] No []

Do you need help with cost of materials? Yes [] No []

Do you have someone that can complete the modification for free? Yes [] No []

Vehicle modification what modifications are needed to make vehicle safer for person with disability?

_____
_____

Specialized equipment repair maintenance what specialized equipment is needed? Specialized equipment is equipment recommended by doctor or therapist such as weighted vest communication devices.

_____
_____

Specialized nutrition clothing supplies what is needed? Specialized nutrition includes gluten free, boost or insure, and feeding tube formulas. Specialized clothing includes clothing such as special orthotic shoes compression shirts, ripstop clothing, or other clothing that is specially made for disabilities. Specialized supplies include diapers, wipes, bed mats, mattress covers, and some other select items depending on disability.

_____
_____

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Personal assistant what type of personal assistance is needed for the person with the disability this can include shopping, trips to doctor appointments, or other needs for accompaniment in the community.

_____
_____

How often is it needed? _____

Medical travel- do you have continual doctor appointments more than an hour away? Yes [] No []

How often? _____

Homemaker- what type of Services is needed? This is for a person with a disability living on their own to help keep the home clean, safe, and possible meal preparation)

_____
_____

Health related- what is the approximate amount that you will be spending on copays for doctor visits and prescriptions, dental, vision, and therapies during the year? $_____

are you in need of other assistance not listed above?

_____
_____

Tell us about the impact the disability has had on your family?

_____
_____

Please share all of the Limitations and daily assistance that is needed for the person with the disability that you were not able to list above: _____

_____
_____

Does the individual with a severe disability reside in a home, either alone or with a parent, relative, or caregiver? Alone [] with someone []

If living with someone, then who do they live with? _____

Are the parents/caregiver aged 65 or older? Yes [] No []

Does the individual reside in a state/federally funded setting where there is a paid caregiver? *This includes settings such as group homes, state funded foster homes, sheltered apartments, and institutions.* Yes [] No []

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Washington County

Does the individual receive assistance from any of the following programs: the DIDD, ECF, Choices, or state funded foster care? Yes [] No []

Have you received family support funding in the past? Yes [] No []

If yes, when was the last year? _____ How many years have you received family support?_____

Are you receiving any other services such as nursing, respite, homemaker, in school therapies?

Yes [] No [] If yes, what? _____

Have you submitted proof of disability with this application or in the past? *(Proof includes IEP, doctor signed note or health professional diagnosis)* Yes [] No []

Have you submitted proof of citizenship with the application or in the past? *(Proof includes copy of certified birth certificate or US passport)* Yes [] No []

Have you submitted proof of residency with this application? *Residency must be submitted every year. (Proof includes rent lease, mortgage statement, or utility bill that has occurred in the last 60 days of application)* Yes [] No []

NOTE: Applications are not complete unless we have required documentation for proof of disability, proof of citizenship and current proof of residency and cannot be considered for allocation. If you are not able to provide one of the documents, contact the office to discuss possible options.

The following information is regarding any parent or guardian that lives in the home with the person with the disability.

Are you the primary income source for the family? Yes [] No []

Do you work outside of the home? Yes [] No [] If no, why? _____

Does the consumer attend school? Yes [] No []

Is there another parent or guardian that works outside of the home that provides some income to person with disability? Yes [] No []

How many individuals in the household are dependent upon you? _____ What are these individuals ages? _____

Do any others have a disability? Yes [] No []

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Do you have natural supports that do not live in the home? Yes [] No [] Answer yes or no to each:

Grandparents? Yes [] No [] Siblings? Yes [] No [] Friends? Yes [] No [] Parents? Yes [] No []

I certify by my signature below that the above information is true and correct. I also am aware that any falsification of any information will result in my immediate termination from the family support program.

Signature_____ Date _____