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: _____