

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:

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

Before/After Care

Behavior Services

Day Care

Education/Home School/Tuition

Emergency Living Expenses

Family Counseling

Funeral/End of Life Expenses

Health Related

Home Modifications

Homemaker Services

Nursing/Nurse’s Aid

Personal Assistance

Recreation/Summer Camp

Respite

Service Animal

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- Inclusive Care 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

□None

* ECF Choices □ DDA Waivers □ Katie Beckett Program □ Any in home or community supports

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

**1. RACE (Check all that apply)** □ American Indian/Alaskan Native □Asian □ Black or African American □ Hispanic or Latino

* Middle Eastern or North African ☐Native Hawaiian or Pacific Islander □ White □Other (including 2 or more races)



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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: