TN Department of Disability & Aging | 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: _____

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 ☐ ECF Choices ☐ DDA 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)** ☐ 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: _____