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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | | | | **Consumer Intake Report** | | | | | | | | | | | | | | | | | | | | Date of intake: | | | | | | Click here to enter a date. | | | | | |
| (Form Updated 6/2016) | | | | | | | | | | | | | | | | | | | | Staff completing intake: | | | | | | Click here to enter text. | | | | | |
| **Last Name:** | | | | Click here to enter text. | | | | | | | | | | | | | | **First Name:** | | | | | | Click here to enter text. | | | | | | | | | | | **Mi:** | text | |
| **Address:** | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **City/State/Zip:** | | | | | | | Click here to enter text. | | | | | | | | | | | | | | | | | | | | | | **County:** | | | | text | | | |
| **Primary Phone:** | | | | | | | | Click here to enter text. | | | | | | | | | | | | | | | | | | | **Other Phone:** | | | | text | | | | | |
| **E-mail:** | | Click here to enter text. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Primary Disability:** | | | | | | | | | | Click here to enter text. | | | | | | | | | | | | | | | | | | Onset Date: | | | | | text | | | |
| Other Disabilities: | | | | | | | | Click here to enter text. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **DOB:** | Text | | | | | | | **Gender:** | | | | | | | | | Female | | | | Male | | | | | | | | | | | | |
| **Ethnicity:** Hispanic or Latino | | | | | | | | | | | | | Yes | | No | | | | | | | | | | | | | | | | | | | | | |
| **Race:** | American Indian/Alaska Native | | | | | | | | | | | | | | | | | Asian | | | | Black/African American | | | | | | | | | | | | | | |
|  | Native Hawaiian/Other Pacific Islander | | | | | | | | | | | | | | | | | | | | White | | | | | Other: Click here to enter text. | | | | | | | | | | |
| Do you receive Voc Rehab Services? | | | | | | | | | | | | | | | | Yes | | | | No | | | Pending | | | | | | | | | | | | | |
| Are you a veteran? | | | | | | | | | Yes | | | No | | If yes, is disability service-connected? | | | | | | | | | | | | | | | | Yes | | No | | | | |
| **Are you registered to vote:** | | | | | | | | | | | | Yes | | No | | | | | No, and would like help registering | | | | | | | | | | | | | | | | | |
| Referral Source: | | | | | | Click here to enter text. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Service(s) Requested:** | | | | | | | | | | | Click here to enter text. | | | | | | | | | | | | | | | | | | | | | | | | | |

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| --- |
| Notes: Click here to enter text. |

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| --- |
| **For staff use only:** |

A person is eligible for center services if they have a significant disability and if our services will benefit them. The presence of a disability may be based on self-report. The above consumer is eligible for services.

|  |  |  |  |
| --- | --- | --- | --- |
| **Staff Signature:** |  | **Date:** |  |

## **Independent Living Plan (check one box):**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | I choose to develop goals within an Independent Living Plan (complete separate Independent Living Plan form and attach to this intake). | | | |
|  | At this time, I have decided that developing goals in a formal Independent Living Plan document is unnecessary. I understand that the services I receive from Independence, Inc. will not be affected by this decision. I also understand that at any time I may reconsider and choose to develop an Independent Living Plan for organizing my goals. (Sign below) | | | |
|  | Signed: |  | Date: |  |
|  | | (consumer, parent/guardian, or advocate) |  |  |

## **Acknowledgement of Information Provided**

I acknowledge that I have been notified of the Independence, Inc. Grievance Policy & Procedure which includes how to contact the Client Assistance Program at the Disability Rights Center of Kansas (1-877-776-1541) which is available to assist me during any phase of the grievance process.

I acknowledge that I have been informed of the Independence, Inc. Notice of Privacy Practices based on the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

A copy of the above was offered and received in the following format:

Print  Large Print  Braille  E-mail  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| Signed: |  | Date: |  |
|  | (consumer or parent/guardian) |  |  |

## **Emergency, Alternative, or Guardian Contact Release of Information**

**(Optional, unless under 18 or have legal guardian)**

I hereby authorize the staff at Independence, Inc. to contact the person(s) listed below, if necessary, during or following an emergency when I am at the agency, using agency transportation, or attending an agency activity. I also authorize agency staff to contact the below listed person(s) in an effort to contact me concerning agency business in the event I become unreachable at my last known address and phone number.

|  |  |  |  |
| --- | --- | --- | --- |
| Contact Name: | Click here to enter text. | | |
| Phone Number: | Click here to enter text. | Relationship: | Click here to enter text. |
| Contact Name: |  | | |
| Phone Number: | Click here to enter text. | Relationship: | Click here to enter text. |

|  |  |  |  |
| --- | --- | --- | --- |
| Signed: |  | Date: |  |
|  | (consumer or parent/guardian) |  |  |