Consumer Intake Report

(Form Updated 4/2021)

Date of intake:

Staff completing intake:

Last Name: _____ **Preferred First Name:** _____ **Mi:** ____

Address: _____

City/State/Zip: _____ **County:** _____

Primary Phone: _____ **E-mail:** _____

Preferred Contact Method: ☐ Email ☐ Phone Call ☐ Text ☐ Other _____

Primary Disability: _____

Other Disabilities: _____

Date of Birth: _____ **Gender:** ☐ Female ☐ Male Pronouns: _____

Hispanic or Latino/a/x?: ☐ Yes ☐ No

Race (select all that apply): ☐ American Indian/Alaska Native ☐ Black/African American

☐ Native Hawaiian/Pacific Islander ☐ Asian ☐ White ☐ Other _____

Are you registered to vote? ☐ Yes ☐ No ☐ No, and would like help registering

Are you a veteran? ☐ Yes ☐ No If yes, is disability service-connected? ☐ Yes ☐ No

Do you receive Voc Rehab Services? ☐ Yes ☐ No ☐ Pending

If 14-24 years old, have you completed or left high school? ☐ Yes ☐ No ☐ Not Applicable

Are you or were you eligible for an IEP? ☐ Yes ☐ No ☐ Not Applicable

Referral Source: _____

Service(s) Requested: _____

Notes:

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. My signature below affirms the above consumer is eligible for services.

Staff Signature: _____ **Date:** _____

☐ Returning Consumer Data entered by (initials): _____ Center Number: _____

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: _____

Phone Number: _____ Relationship: _____

Contact Name: _____

Phone Number: _____ Relationship: _____

Signed: _____ Date: _____
(consumer or parent/guardian)