# Consumer Intake Report

(Form Updated 6/2016)

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|---|
| Date of intake: |
| Staff completing intake: |

**Last Name:** _____ **First Name:** _____ **Mi:** _____

**Address:** _____

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

**Primary Phone:** _____ **Other Phone:** _____

**E-mail:** _____

**Primary Disability:** _____ Onset Date: _____

Other Disabilities: _____

**DOB:** _____ **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:

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: _____

**Service(s) Requested:** _____

Notes:

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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:** _____

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)