TN Department of Intellectual & Developmental Disabilities | Family Support Program

Application for Services

Please complete this application to the best of your ability. Incomplete applications may delay processing.

Applicant Name: _____ **Date:** _____

Date of Birth: _____/_____/_____ **Age:** _____ **Gender:** _____

Address: _____

City: _____ **State:** _____ **ZIP:** _____

Phone: _____ **Email:** _____

Parent/Guardian Name: _____

Relationship to Applicant: _____

Parent/Guardian Phone: _____

Parent/Guardian Email: _____

Emergency Contact Name: _____ **Relationship:** _____

Emergency Contact Phone: _____

Primary Language: _____ **Interpreter Needed?** ☐ Yes ☐ No

Current Living Situation: ☐ Own home ☐ Rent ☐ With family ☐ Group home ☐ Other: _____

Current Employment: ☐ Employed ☐ Unemployed ☐ Student ☐ Retired

Employer: _____ **Work Phone:** _____

Annual Household Income: ☐ Under $15,000 ☐ $15,000–$30,000 ☐ $30,000–$50,000 ☐ Over $50,000

Number in Household: _____

Medicaid Number: _____ **Medicare Number:** _____

Primary Insurance: _____ **Policy Number:** _____

Secondary Insurance: _____ **Policy Number:** _____

Primary Care Physician: _____ **Phone:** _____

Current Medications: _____

Allergies: _____

Diagnosis: _____

Referral Source: _____

Reason for Application: _____

Services Requested: ☐ Case Management ☐ Personal Assistance ☐ Adult Day Care ☐ Respite ☐ Home Delivered Meals ☐ Transportation ☐ Other: _____

Preferred Provider: _____

Applicant Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____

Staff Use Only

Received Date: _____ **Assigned Worker:** _____

Eligibility Determination: ☐ Eligible ☐ Not Eligible ☐ Pending

Reason: _____

Authorized Hours/Units: _____ **Start Date:** _____ **End Date:** _____

Supervisor Approval: _____ **Date:** _____

DIDD-6004 2023/11/9

TN Department of Intellectual & Developmental Disabilities | Family Support Program

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