COMMUNITY SUPPORT SERVICES, INC.
Intake Application

Date of Intake:________________
Completed by:________________

(Incomplete forms will be returned – we can only process completed forms.)

DEMOGRAPHIC INFORMATION (Mandatory)

Name of Applicant:	
	Last Name *First Name* *Middle Initial*

Date of Birth: / Social Security Number:	Marital Status ___Single, Never Married ___Married ___Widow ___Divorced	Gender: ___Male ___Female	U.S. Citizen ___Yes ___No

Medicaid Case Number:	Medicaid Identification Number (RIN): (9 digit number) :	Medicare Number:
Primary Language Spoken ___English ___Spanish ___Other____________________ Interpreter Services Required? ___Yes ___No	Race (required) ___Black or African American ___White ___Asian ___American Indian or Alaska Native ___Native Hawaiian or other Pacific Islander ___Multi-racial	Hispanic Origin? (required) ___Yes, of Hispanic/Latino origin ___No, not of Hispanic/Latino origin

Address of Applicant	Street Address	
	City	
	Zip code	
	Telephone	
	Township	County ___Cook ___Will ___DuPage ___Other__________

Single Parent Home	___Yes ___No	Number of Individuals Living in Home_________
Who is Primary Contact:	___Mother ___Father ___Guardian ___Other (please describe)	Describe Other:

<table>
<tr><td rowspan="8">Mother’s Name

Address
of
Mother</td><td colspan="4"></td></tr>
<tr><td colspan="4">Last Name   First Name   Middle Initial</td></tr>
<tr><td colspan="2">Maiden Name</td><td colspan="2"></td></tr>
<tr><td colspan="2">Street Address</td><td colspan="2"></td></tr>
<tr><td colspan="2">City</td><td colspan="2"></td></tr>
<tr><td colspan="2">Zip code</td><td colspan="2"></td></tr>
<tr><td>Home Telephone</td><td></td><td>Cellular Telephone</td><td></td></tr>
<tr><td>Work Telephone</td><td></td><td>Email Address</td><td></td></tr>
<tr><td rowspan="7">Father’s Name

Address
of
Father</td><td colspan="4"></td></tr>
<tr><td colspan="4">Last Name   First Name   Middle Initial</td></tr>
<tr><td colspan="2">Street Address</td><td colspan="2"></td></tr>
<tr><td colspan="2">City</td><td colspan="2"></td></tr>
<tr><td colspan="2">Zip code</td><td colspan="2"></td></tr>
<tr><td>Home Telephone</td><td></td><td>Cellular Telephone</td><td></td></tr>
<tr><td>Work Telephone</td><td></td><td>Email Address</td><td></td></tr>
<tr><td rowspan="7">Guardian’s Name

Address
of
Guardian</td><td colspan="4"></td></tr>
<tr><td colspan="4">Last Name   First Name   Middle Initial</td></tr>
<tr><td colspan="2">Street Address</td><td colspan="2"></td></tr>
<tr><td colspan="2">City</td><td colspan="2"></td></tr>
<tr><td colspan="2">Zip code</td><td colspan="2"></td></tr>
<tr><td>Home Telephone</td><td></td><td>Cellular Telephone</td><td></td></tr>
<tr><td>Work Telephone</td><td></td><td>Email Address</td><td></td></tr>
<tr><td>Type of Guardian</td><td colspan="2">___Full
___Limited of Person</td><td>___Parent of Minor
___Limited of Estate</td><td>Date of Guardian Assignment</td></tr>
<tr><td rowspan="7">Emergency Contact

Address
of
Emergency
Contact</td><td colspan="4"></td></tr>
<tr><td colspan="4">Last Name   First Name   Middle Initial</td></tr>
<tr><td colspan="2">Street Address</td><td colspan="2"></td></tr>
<tr><td colspan="2">City</td><td colspan="2"></td></tr>
<tr><td colspan="2">Zip code</td><td colspan="2"></td></tr>
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</table>

Emergency Contact's Relationship to Applicant	___Friend	___Neighbor	___Relative
	___Sibling	___Landlord	___Other

Siblings of Applicant	Name	Age	Lives with Applicant (Y/N)

Other Household Members	Name	Age	Relationship

Eating	Dressing	Grooming	Toileting
___Independent	___Independent	___Independent	___Independent
___Needs Training	___Needs Training	___Needs Training	___Needs Training
___Needs Assistance	___Needs Assistance	___Needs Assistance	___Needs Assistance
___Dependent	___Dependent	___Dependent	___Dependent

Level of Mobility	Level of Vision	Level of Hearing
___Walks with or without aids	___Vision is Normal	___Hearing is Normal
___Usually in a wheelchair/does not walk	___Vision is Impaired	___Hearing is Impaired
___Limited to the bed most of the day	___Legally Blind	___Legally Deaf
___Confined to the bed for the entire day	___Unknown/Undetermined	___Unknown/Undetermined

Means of Communication			
	___Sign Language	___Communication Board	___Limited Speech
	___Gestures	___No Communication	___Speaks fluently

DEVELOPMENT DISABILITY ASSESSMENT (MANDATORY)MEDICAL

Primary Disability *(Mark only one)* Age of onset: ______________	___Autism ___Intellectual Disability(Borderline) ___ Intellectual Disability (Mild)	____Intellectual Disability (Moderate) ____Intellectual Disability (Severe)
Secondary Disability *(Mark all that apply)* *Age of onset must be listed beside each checked disability*	___Autism ___Hearing Impaired ___Neurological Impairment ___Visual Impairment ___Physical/Medical Disability ___Cerebral Palsy ___Visual Impairment ___Prader-Willi Syndrome ___Behavior Disorder ___Mental Health Issues:_______________________________ ___Other:_______________________________________	___ Intellectual Disability (Borderline) ___ Intellectual Disability (Mild) ___ Intellectual Disability (Moderate) ___ Intellectual Disability (Severe) ___Epilepsy/Seizures ___Traumatic Brain Injury ___Communication Impairment ___Fetal Alcohol Syndrome
Descriptive Behaviors		

Medications	Purpose and Side Effects

Medical Issues		
Allergies	Description	Reactions

EDUCATION INFORMATION

Educational Level of Applicant	___Never Attended School ___Preschool/Kindergarten ___Primary School, grade ____ ___Secondary School, grade ____ ___High School, grade ____ ___High School Diploma	___General Equivalency Diploma (GED) ___Special Education Certificate of Completion ___Post-Secondary Training (certificate) ___College, enter years completed ____
Does applicant currently attend school? ___Yes ___No	Name and address of school:	School District # ______________________ Special Education Coop: _____________________________________
Educational Comments		
Does applicant have any interests, hobbies or activities that he/she enjoys?		

APPLICANTS EMPLOYMENT INFORMATION

Employment Status of Applicant	___Employed, on vacation/sick leave ___Employed full time *(unsubsidized employment including self-employment)* ___Employed part time *(unsubsidized employment including self-employment)* ___Employed *(full or part time)* in subsidized or supported employment	___ Attending vocational/day program, including programs funded by DHS or other entities ___Unemployed/layoff from job ___Not in labor force *(retired, homemaker, student, resident)* ___Other *(not seeking employment or vocational services)* ___Volunteering
Employment Comments		

Is applicant currently serving in the military?	___Not a Veteran ___Veteran ___Currently on active duty ___Unknown

APPLICANTS INCOME INFORMATION

Annual Adjusted Taxable Household Income		Adult applicant's estimated Annual Income
___$30,000 or less	___$60,626 to $69,000	SSI $_______________
___$30,000 to $39,000	___$70,000 to $79,000	SSDI $_______________
___$40,000 to $49,000	___$80,000 to $89,000	Income $_______________
___$50,000 to $59,000	___$90,000 to 99,000	Other $_______________
	___$100,000 or above	
SSI/SSDI Eligibility ___Eligible, receiving payments ___Eligible, not receiving payment ___Eligibility determination pending ___Potentially eligible but not applied ___Determined to be ineligible ___Not applicable ___Unknown		Please describe other:

Income Comments	

SERVICES SOUGHT

Primary Services being sought	___Respite care for minor child ___Respite care for adult child ___Parenting support for adult with intellectual disabilities ___Employment support ___Independent living skills	___Placement for 24-Hour Services (Adult) ___Case Management ___Social Group for adult ___Social Group for child ___Other ________________________________
How would you rate the level of services needed	___Emergency/Crisis ___High level of need ___Moderate level of need ___Low level of need ___Other	Additional comments:
Are you receiving services from any other agency? ___Yes ___No	Name of Agency	Services being received

Does the applicant receive Home Based Support Services (HBSS) Medicaid funding? ___ Yes ____ No
Does the applicant receive Illinois Department of Rehabilitation Services (DRS) Home Services funding? ____ Yes ____ No

I understand that this application does not guarantee that I will receive services from Community Support Services. My signature means that the information contained is accurate to the best of my knowledge. (Reminder – incomplete forms will be returned – we can only process completed forms. For expedited processing please enclose a copy of applicant's IEP or Medical Diagnosis)

________________________________ Date ________________

Printed Name

____

Signature

For Agency Use Only

Date initially Contacted		*Intake form mailed to applicant*		*Intake form received from applicant*	
Determination of service eligibility		*Program enrollment and/or waitlist*			
Additional Comments:					