AACOG
Alamo Area Council of Governments

**INTAKE AND ELIGIBILITY APPLICATION**

**Please submit this completed application to:**
**IDD Services**
**Attn: Intake & Eligibility**
**2700 NE Loop 410, Suite 101**
**San Antonio, TX 78217**
**or**
**Fax to 1-866-689-1843 Attn: IDD Intake & Eligibility**

**The following documents are required before we can schedule the Determination of an Intellectual Disability (DID) appointment**

- Proof of Residency verifying the individual resides in Bexar County.
- Proof of Income must be provided at the time of the intake appointment. If the individual is under the age of 18, proof of the family income must be provided. If the individual is over the age of 18, proof of their income must be provided. (income tax return or W2, if income tax was not filed then 3 months of current pay stubs, current SSI award letter)
- Special Education Testing from the School District(s) attended by the individual (the Full and Individual Evaluation)
- Doctor's Letter, previous Psychological evaluations or assessments
- Social Security Card
- Birth Certificate
- Insurance Information (Private Insurance Card, or Medicaid Letter)
- Health/Medical Information
- Any other Legal documents (Conservatorship Order, Letters of Guardianship, Adoption papers, Divorce Decree, Custody papers, etc.)

*Also, please complete as much of the information on the attached as possible.*
*This will assist us in completing your appointment quickly.*

***If you have any questions, or need special accommodations for your appointment (E.g. interpreting services, assistive listening devices, or wheelchair accommodations) please contact us at (210) 832-5020***

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# INTAKE AND ELIGIBILITY APPLICATION

Name: _____

Case#: _____

Cost Center: _____

Sub Unit #: _____

## Determination of an Intellectual Disability (DID)
## Demographic Information

Individual Name: _____ Age (Years/Months): ____ / ____ DOB: ____ / ____ / ____

Social Security Number: _____ Federal Race: _____ Ethnic Heritage: _____

**Parent/Guardian Information:**

Parent/Guardian Name _____ Relationship to Individual _____

Parent/Guardian Address _____City_____State._____Zip_____

Parent/Guardian Phone Number _____ Alternate Phone Number _____

Emergency Contact Name _____ Relationship to Individual _____

Emergency Contact Address _____City_____State_____Zip_____

**Financial Information:** **Monthly**

| | | | |
|---|---|---|---|
| Individual Employment | $ _____ | Child Support | $ _____ |
| Supplemental Security Income (SSI) | $ _____ | Food Stamps | $ _____ |
| Social Security Disability Insurance (SSDI) | $ _____ | Retirement | $ _____ |
| Social Security | $ _____ | Unemployment | $ _____ |
| Parents | $ _____ | Extraordinary Expenses1 | $ _____ |
| Other | $ _____ | Extraordinary Expenses2 | $ _____ |
| Total Monthly Income | $ _____ | _____ | $ _____ |

**Insurance Information:**

| Insurance Company Name | Effective Date | Expiration Date | Policy ID Number |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Name: _____ DOB: _____ Case Number: _____

BIOPSYCHOSOCIAL HISTORY

Please complete as much of this form as possible before your Intake appointment. A Care Specialist and/or Psychological Examiner will review this entire form with you. If you are unsure how to answer a question, help will be available to you at the time of your Intake appointment. Many of these items may not apply to your Applicant and you may skip over them.

Do not labor over any questions or let this form become a source of stress. We recognize we are asking many questions and you may have answered these same types of questions before in other places. Please know that we have considered each question carefully to ensure that it is important to assessing the Applicant's eligibility for service through the IDD Services and the Department of Health and Human Services. We have attempted to make the completion of this form as simple yet as thorough as possible. We thank you in advance for taking the time to answer these questions in behalf of the Applicant.

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Alamo Area Council of Governments

Name: _____ DOB: _____ Case Number: _____

## BIOPSYCHOSOCIAL HISTORY

Name of person needing services (Applicant): _____

Gender: ☐ Male ☐ Female Date of Birth: _____ Current Age: _____

Name of Person Completing this form: _____

Relationship to Applicant: _____

### Social History

*Please mark who the Applicant currently lives with:*

☐ With biological parent(s) ☐ With other relatives ☐ Independently
☐ With biological parent & step parent ☐ Legal guardian ☐ In a group home
☐ With adoptive parent(s) ☐ With a spouse ☐ _____
☐ With foster parent(s) ☐ With a friend

Is there anything about the Applicant's living circumstances that are distressing to them or you at this time? ☐ Yes ☐ No

*If you answered yes, you will have the opportunity to discuss this with as much detail as you think necessary at the time of your Intake Appointment.*

### Family Origin (Biological Family)

| Relationship | Name | Living/Deceased/Unkown | |
|---|---|---|---|
| Father | | | ☐ Living in Home |
| Mother | | | ☐ Living in Home |
| Sibling | | | ☐ Living in Home |
| Sibling | | | ☐ Living in Home |
| Sibling | | | ☐ Living in Home |
| Other | | | ☐ Living in Home |

*If more, you may use the back of this page.*

What is the total number of children born to the Applicant's birth mother? _____

What is the number of the Applicant in the birth order? _____

Is there any history of the following conditions in the family of origin? ☐ Yes ☐ No ☐ Unknown

*Mark all that apply.*

☐ Intellectual Disability / Mental Retardation ☐ Autism / PDD / Aspergers ☐ ADHD
☐ Mood Disorder / Depression / Bipolar ☐ Prescription Drug Abuse ☐ Alcohol Abuse
☐ Psychosis / Schizophrenia / Epilepsy ☐ Other Drug Abuse ☐ Unknown

### Health

Did the Applicant's Birth Mother receive prenatal care during her pregnancy?

☐ Yes ☐ No ☐ Unknown

Please mark any of the following that the birth mother was exposed to during the pregnancy.

☐ Alcohol ☐ Illegal Drugs ☐ Toxins
☐ Cigarettes of any type ☐ InhIDDnts ☐ Unknown
☐ Over the Counter Medications ☐ Prescription Medications

IDD NOTES
FOR IDD USE ONLY

Name: _____ DOB: _____ Case Number: _____

Please mark descriptions of pregnancy as they apply.

- ☐ Normal
- ☐ Complicated by medical issues
- ☐ Full Term
- ☐ Complicated by mother's age (before 18 or after 35)
- ☐ Unknown

Please mark descriptions of Applicant's birth as they apply.

- ☐ Born near due date
- ☐ Born more than 2 weeks before anticipated
- ☐ Told that baby was experiencing distress necessitating quick delivery
- ☐ Uncomplicated delivery
- ☐ Cesarean section delivery
- ☐ Breech presentation
- ☐ Unknown
- ☐ Labor induced

Please mark descriptions of the Applicant's health as a newborn as they apply.

- ☐ Good health
- ☐ Baby required surgery before leaving hospital
- ☐ Health problems at birth
- ☐ Baby had trouble breathing
- ☐ Unknown

The Applicant's birth weight was _____ lbs _____ oz

The Applicant left the hospital with mother after _____ days.

The Applicant had to remain in the hospital after mother's discharge. How long? _____

Types of treatments the Applicant needed before leaving the hospital. _____

Please mark descriptions of the Applicant's first year of life as best you know or can recall.

- ☐ The applicant seemed to develop normally at first, then began losing abilities
- ☐ Normal infancy-similar to other children in the family
- ☐ Normal toddler-similar to other children in the family
- ☐ Did not sit up by 8 months
- ☐ Did not crawl by 10 months
- ☐ Did not walk by 15 months
- ☐ Strangers could not understand this child's speech by 15 months
- ☐ Did not speak 2 word sentences by 2 years
- ☐ Did not stay dry during the day by 3 1/2 years
- ☐ Did not read simple words by 6 years
- ☐ Irritable
- ☐ Cried more than most babies
- ☐ Difficult to soothe
- ☐ Many health problems
- ☐ Problems with hearing
- ☐ Problems with vision
- ☐ Overly sensitive to sound or light
- ☐ Unknown

When did you or someone else first have concerns about the Applicant's development?

_____

Please mark any conditions for which the Applicant has received a formal diagnosis.

| Condition | Age | Diagnosis made by |
|---|---|---|
| ☐ Developmental Delay | | |
| ☐ Pervasive Developmental Disorder | | |
| ☐ Asperger's Disorder | | |
| ☐ Autism | | |
| ☐ Epilepsy | | |
| ☐ Cerebral Palsy | | |
| ☐ Down Syndrome | | |
| ☐ Other: | | |

IDD NOTES

FOR IDD USE ONLY

Name: _____ DOB: _____ Case Number: _____

Do you have documentation of medical diagnoses or conditions with a doctor's signature?

☐ Yes ☐ No

| IDD NOTES |
|---|
| FOR IDD USE ONLY |

At any time has the Applicant been hospitalized for:

| | Explain | Age |
|---|---|---|
| ☐ Serious illness(es)? | | |
| ☐ Surgery(ies)? | | |
| ☐ Head injury? | | |
| ☐ Other conditions? | | |

Please list all Medications the Applicant is now taking.

| Medication | Reason |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

Does the Applicant have any known allergies? ☐ Yes ☐ No ☐ Unknown

*If yes, mark the type.*

| | Describe |
|---|---|
| ☐ Airborne/Seasonal | |
| ☐ Foods | |
| ☐ Medications | |
| ☐ Other | |

Please mark descriptions of the Applicant at the present time.

- ☐ Enjoys good health
- ☐ Health problems but they are stable
- ☐ Has many ongoing health problems
- ☐ Walks without assistance
- ☐ Needs assistance walking
- ☐ Needs a wheel chair
- ☐ Self propels wheel chair
- ☐ Drives an electric wheel chair
- ☐ Toilet trained
- ☐ Has toileting accidents
- ☐ Needs assistance with toileting
- ☐ Speaks full sentences
- ☐ Speaks in phrases
- ☐ Speaks in Sign Language
- ☐ Does not speak but makes gestures
- ☐ Does not speak or gesture
- ☐ Speaks English only
- ☐ Speaks Spanish only
- ☐ Speaks only: _____
- ☐ Bilingual in _____ *(Please state languages)*

## Education

Mark those that apply to the Applicant.

- ☐ Before the age of 3, the applicant (or is receiving) Early Childhood Intervention services OT, PT, Speech
- ☐ The Applicant entered a public school PPCD program at 3 years of age
- ☐ The Applicant entered a public or private school at the usual age (5 or 6)
- ☐ The Applicant was placed in Special Education Services
- ☐ The Applicant is in Special Education services at the present time

Name: _____ DOB: _____ Case Number: _____

Please mark any of the following Special Education eligibility conditions that the Applicant's school has identified

- ☐ Non Categorical Early Childhood
- ☐ Intellectual Disability
- ☐ Traumatic Brain Injury
- ☐ Speech and Language Impairment
- ☐ Hearing Impairment
- ☐ Autism Spectrum Disorders (Autism-PDD)
- ☐ Visual Impairment
- ☐ Other Health Impairment
- ☐ Specific Learning Disability
- ☐ Orthopedic Impairment
- ☐ Multiply Handicapped
- ☐ Emotional Disturbance

If the Applicant is currently in school. What grade? _____

| | Yes | No | Unk |
|---|---|---|---|
| Has the applicant had a Full and Individual Evaluation or a Reevaluation Review within the last year? | ☐ | ☐ | ☐ |
| Do you have a copy? (If Yes, please bring to your appointment). | ☐ | ☐ | |
| Is a Full and Individual Evaluation or Reevaluation Review planned in the next year? | ☐ | ☐ | ☐ |
| At any time, has the Applicant had a Psychological Evaluation? | ☐ | ☐ | ☐ |
| Do you have a copy? (If Yes, please bring to your appointment). | ☐ | ☐ | |
| Has the Applicant ever participated in Special Olympics? | ☐ | ☐ | ☐ |
| Has Applicant graduated from High School? | ☐ | ☐ | ☐ |
| Has Applicant earned GED certificate? | ☐ | ☐ | ☐ |

## Daily Activity for Applicants Beyond School Age

Please mark all that apply.

- ☐ The Applicant has a job at this time
- ☐ Full time
- ☐ Part time
- ☐ Sheltered or Supported Employment
- ☐ The Applicant has been employed in the past
- ☐ The Applicant stays home most days
- ☐ Stays home alone
- ☐ Stays home with caregiver
- ☐ The Applicant attends a structured day activity program or sheltered workplace

## Behavioral/Psychiatric/Legal History

Please mark all that apply.

- ☐ The Applicant has received counseling for personal problems
- ☐ The Applicant has received the services of a Behavioral Specialist, ABA Therapist, or Psychologist to address unwanted behaviors
  - ☐ At Home ☐ At School ☐ At Both
- ☐ The Applicant has received outpatient services from a Psychiatrist
- ☐ The Applicant has been treated with psychiatric medications to help manage behavioral or emotional problems
- ☐ The Applicant has been arrested by law enforcement
- ☐ The Applicant has been incarcerated

IDD NOTES

FOR IDD USE ONLY

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## FOR IDD USE ONLY

### Statement of Necessity

Is standardized psychometric assessment necessary to establish eligibility for IDD services as specified by TDADS or to meet the administrative requirements of a court or service provider? ☐ Yes ☐ No

Suggestions for Assessment:

Intelligence Scales: _____

Adaptive Scales: _____

ASD Scales: _____

Other: _____

| | | |
|---|---|---|
| Applicant Signature | Printed Name / Relationship | Date |
| Person Completing Form's Signature | Printed Name / Relationship | Date |
| CARE Specialist Signature | Printed Name | Date |
| Psychological Examiner Signature | Printed Name | Date |