

Intake Date _____

Second Case this FY: Yes _____ No _____

Case _____

**STATE OF ALABAMA
CLIENT ASSISTANCE PROGRAM
INTAKE WORK SHEET**

Name _____

Address _____

City State Zip County

DOB _____

Social Security Number

Primary Phone

Cell Phone

Fax

E-Mail

DISABILITY

- _____ Acquired Brain Injury
- _____ ADD/ADHD
- _____ AIDS/HIV
- _____ Amputation or Absence of Extremities
- _____ Arthritis or Rheumatism
- _____ Anxiety Disorder
- _____ Autism Spectrum Disorder
- _____ Blindness (Both Eyes)
- _____ Other Visual Impairments (Not Blind)
- _____ Cancer
- _____ Cerebral Palsy
- _____ Deafness
- _____ Deaf-Blind
- _____ Hard of Hearing/Impaired (Not Deaf)
- _____ Diabetes
- _____ Digestive Disorders
- _____ Epilepsy

- _____ Specific Learning Disabilities (SLD)
- _____ Speech Impairments
- _____ Spina Bifida
- _____ Heart & Other Circulatory Conditions
- _____ Intellectual Disability
- _____ Mental Illness
- _____ Multiple Sclerosis
- _____ Muscular Dystrophy
- _____ Muscular/Skeletal Impairment
- _____ Neurological Disorders/Impairment
- _____ Orthopedic Impairments
- _____ Personality Disorders
- _____ Respiratory Disorders/Impairment
- _____ Skin Conditions
- _____ Substance Abuse (Alcohol or Drugs)
- _____ Other Disability
- _____ N/A

RACE/ETHNICITY

- _____ American Indian or Alaskan Native
- _____ Asian
- _____ Black or African American
- _____ Hispanic/Latino of Any Race
- _____ Latino Only (Non-Hispanic)
- _____ Native Hawaiian or Other Pacific Islander
- _____ Race/Ethnicity Unknown
- _____ Two or More Races
- _____ White

Counselor Name

Supervisor Name

Facility Name

**PROBLEM INFORMATION
PROBLEM AREAS
(MULTIPLE RESPONSES PERMITTED)**

- _____ Communication Problems between Individual and VR Counselor
- _____ Conflict about VR Services to be Provided
- _____ Housing
- _____ Individual Requests Information
- _____ Non-Rehabilitation Act Related
- _____ Other Rehabilitation Act Related Problems
- _____ Related to Assignment to Order of Selection Priority Category
- _____ Related to Independent Living Services
- _____ Related to IPE Development/Implementation
- _____ Related to Title I of the ADA
- _____ Related to VR Application/Eligibility Process
- _____ Selection of Employment Outcome
- _____ Selection of Training Services Including Postsecondary Education
- _____ Selection of Vendors for Provision of VR Services
- _____ TANF
- _____ SSI/SDI
- _____ OTHER
- _____ N/A

CONCERN EXPLANATION

ASSISTANCE OBJECTIVE

Report the stated concern to the consumer's rehabilitation counselor, and if warranted or necessary, help work out a mutually acceptable solution.

ADDITIONAL INFORMATION

- _____ Applicant of VR
- _____ Applicant or Individual Eligible for Independent Living
- _____ Individual Eligible for VR Services Currently on a Wait List
- _____ Individual Eligible for VR Services Not Currently on a Wait List
- _____ Transition Student / High School Student
- _____ All Other Applicants or Individual Eligible for Other Programs or Projects Funded Under the Rehabilitation Act

DESIGNATED AGENCY

- _____ External / All Other Private Agencies
- _____ External / Other Non-Profit Agency
- _____ External / Other Public Agency
- _____ External Protection and Advocacy Agency
- _____ Internal to the State VR Agency

Name of Designate Agency _____
Is the Designated Agency Contracting CAP Services? Yes _____ No _____
If yes, Name of Contracting Agency _____