Intake Date:_____ Second Case this Fiscal Year?_____

Consumer's Advocate:_____ Case #:_____

Name:_____

Address:_____

_____

City State Zip

SSN:_____ DOB:_____ County:_____

_____ _____ _____

Primary Phone Cell Phone# Fax#

_____ Additional Info/Notes: _____

Email Address _____

_____

_____

Race/Ethnicity _____

_____

___American Indian/Alaskan Native _____

___Asian _____

___Black/African American _____

___White _____

___Race/Ethnicity Unknown _____

Disability

___Blindness (both eyes)
___Other visual impairments
___Deafness
___Orthopedic impairments
___Absence of extremities
___Deaf-Blind
___Mental illness
___Mental retardation
___Specific learning disabilities (SLD)
___Neurological disorders
___Respiratory disorders
___Heart & other circulatory conditions
___Digestive disorders
___Genitourinary Conditions
___Speech impairments
___AIDS/HIV positive
___Traumatic brain injury (TBI)
___All other disabilities
___Disability unknown

Problem Information

Problem Areas
(Multiple responses permitted)

__ Individual request information
__Communication problems between individual and counselor
__Conflict about services to be provided
__Related to application/eligibility process
__Related to IPE development/implementation
__Other Rehabilitation Act-related problems
__Non Rehabilitation Act related
__Related to Title I of the ADA

Additional Information

__Applicants of VR program
__Client of VR program
__Applicant of Independent Living Program
__Applicants or clients of other programs and projects funded under the act.

_VR Agency only
_Other rehabilitation sources only
_Both VR & other rehabilitation Act source
_Employer

Counselor Name:_____

Supervisor Name:_____

PLEASE NOTE!
This form must remain in the case file of:

SACAP Form 12
Revised 2/99

INFORMATION RELEASE FORM

I, the undersigned, hereby permit the Alabama Department of Rehabilitation Services and the State of Alabama Client Assistance Program to exchange written, verbal or computerized information for the purpose of resolving a concern about my rehabilitation program I reported to the State of Alabama Client Assistance Program. I also permit the State of Alabama Client Assistance Program to have full access to all materials in my current Alabama Department of Rehabilitation Services case file in whatever form it may be recorded, stored or held.

I understand the information released to the State of Alabama Client Assistance Program will only be used to help resolve the concern reported to the State of Alabama Client Assistance Program. It will only be discussed or shared with rehabilitation personnel and service providers who are part of my rehabilitation program or who evaluate my progress toward my vocational goal.

I further understand the State of Alabama Client Assistance Program may not release any information about me without my written or verbal consent when required by federal or state law or when necessary to protect me or the safety of others.

This Information Release Form becomes effective on the date I sign it and ends six (6) months from that date. If that date falls on a weekend or State holiday, it will end the next business day. However, I may cancel this release at any time by notifying, in writing, the State of Alabama Client Assistance Program at 400 South Union Street, Suite 465, Montgomery, AL 36104. Canceling this release does not change any action already taken under this release. The State of Alabama Client Assistance Program may also cancel this release by notifying me in the manner most appropriate for my disability.

Print Your Name_____ Date Signed_____

Your Signature_____ Your Telephone Number_____
(By signing your name you are agreeing with and acknowledging that you have read the above statement)

Your Social Security Number
_____

Representative's Signature (If not signed by Consumer) _____

The County in which you live
_____

Relationship to Consumer (If signing for Consumer) _____