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_____

_____ _____

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

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

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_____

Information Release Form

PLEASE NOTE!
This form must remain
In the file of:_____

SACAP Form 12
Revised 04/2017

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.

This Information Release Form becomes effective on the date I sign it and ends when the case is closed. I may cancel this release at any time by notifying, in writing, the State of Alabama Client Assistance Program at 400 South Union Street, Montgomery, AL 36104. Cancelling 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

The County in Which You Live

Representative's Signature
(if not signed by Consumer)

Relationship to Consumer
(if signing for Consumer)