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_____