

**The FREEDOM CENTER**

For Independent Living, Inc.



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**People Empowering People**

# ***Consumer Intake Packet***

***Freedom Center for Independent Living, Inc.***

*400 North Broad Street · Middletown · Delaware · 19709*

*(302)376-4399 F(302)376-4395*

*[www.fcilde.org](http://www.fcilde.org)*

11/12/2020

**Intake Form**

Consumer Name: \_\_\_\_\_

Address : \_\_\_\_\_

County: New Castle  Kent  Sussex  Out of State

Ethnicity: African-American  Asian Pacific  Hispanic

Native-American Indian  Caucasian  Other

How Did You Find Out About Freedom Center : \_\_\_\_\_

Disability(s): \_\_\_\_\_

Limiting Factors of Disability(s) : \_\_\_\_\_

Telephone Number(s):

Home: \_\_\_\_\_

Work \_\_\_\_\_

Fax \_\_\_\_\_

TDD \_\_\_\_\_

Email \_\_\_\_\_

Contact By: Phone \_\_\_ Fax \_\_\_ Email \_\_\_ Mail \_\_\_ Other \_\_\_

Needs/Potential Goals: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Freedom Center for Independent Living, Inc.

Follow-up Action taken: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Independent Living Specialist \_\_\_\_\_ Date \_\_\_\_\_

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**Emergency Contact Form**

Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

***Primary Emergency Contact***

Name: \_\_\_\_\_

Relationship : \_\_\_\_\_

# Contact Number: \_\_\_\_\_

Type: \_\_\_\_\_

***Secondary Emergency Contact***

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Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

#2 Contact Number: \_\_\_\_\_

Type: \_\_\_\_\_

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Primary Care Physician: \_\_\_\_\_ Phone#: \_\_\_\_\_

Medical Conditions: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Allergies: \_\_\_\_\_

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**Consumer Profile**

Consumer Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number(s): Home \_\_\_\_\_ Work \_\_\_\_\_

Fax \_\_\_\_\_ TDD \_\_\_\_\_

Email: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Sex: Male

Female

Age \_\_\_\_\_

Are you a military veteran? Yes  No

What is your level of education? Elementary  High School  GED

College  Special Education

What is your marital status? Single  Married

Divorced  Separated  Widowed

What do you consider to be your ethnicity? African-American  Caucasian

Asian-Pacific Islander  Hispanic  Native American -Indian  Other

Have you applied for Vocational Rehabilitation Services? Yes  No

If YES: When? \_\_\_\_\_

Current Status: Active  Inactive

If ACTIVE: Vocational Rehabilitation Counselor: \_\_\_\_\_

- 1. What is your employment status? Full-Time  Part-Time
- Retired  Not Working/Have Worked  Supported
- Never Worked

What mode of transportation can you use? Public  Personal  DART

What are your current living arrangements? Live Alone  live with Spouse

2. Live with Parent/Guardian  Live with Primary Caregiver

3. live in a Supervised Residence  Other  \_\_\_\_\_

4. Do you have an attendant? Yes  No

5. What is your annual income?  
\$0-\$5,000  \$5,001-\$10,000  \$10,001-\$15,000   
\$15,001-\$20,000  Over \$20,000

6. Are you registered to vote? Yes  No

7. If No, would you like to Register at Freedom Center? Yes  No

8. What is your primary disability? \_\_\_\_\_

9. What other disabilities do you have? \_\_\_\_\_

10. How did you learn about the Freedom Center? \_\_\_\_\_

11. Were you referred by another organization? Yes  No

12. If yes, what is the name of the organization? \_\_\_\_\_

13. COMMENTS:

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Consumer's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Independent Living Specialist Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**Consumer Significant Disability Statement**

Consumer Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ County of residence: \_\_\_\_\_

Consumer Stated Significant Disability(s) [Optional]: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

I acknowledge that I \_\_\_\_\_ am a person with a significant disability which limits my ability to perform at least two activities of daily living. \*Due to my disability I am eligible for services from Freedom Center for Independent Living. I understand that the Freedom Center for Independent Living provides services to individuals with significant disabilities. As a person with a significant disability, I request assistance in my effort to live independently in the community.

Consumer's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Independent Living Specialist Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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\*13.1 Eligibility for Receipt of Services (secs.7 (15) (B) and 703 of the Act; 34 CFR 364.51  
(a) Individuals with significant disabilities are eligible for services provided under SPIL.  
(B) To be eligible, an individual is one: (1) Who has a significant physical, mental, cognitive, or sensory impairment; (2) Whose ability to function independently in the family or community or whose ability to obtain, maintain or advance in employment is substantially limited; and (3) For whom the delivery of independent living services will improve the ability to function, continue functioning, or move towards functioning independently in the family or community or to continue in employment.



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**Confidentiality Policy - Consumer Sign-Off**

All Freedom Center records and information relating to Freedom Center or its Consumers are to be held strictly confidential. Therefore, every Freedom Center employee is mandated to treat all related matters accordingly. No Freedom Center, or Freedom Center related information, including, without limitation, documents, notes, files, records, oral information, computer files or similar materials (except in the ordinary course of performing duties on behalf of Freedom Center) may be removed from Freedom Center's premises without permission of the Executive Director. Additionally, the contents of Freedom Center's records or information otherwise obtained in regard to the Freedom Center or its Consumers may not be disclosed to anyone, except where required for a Freedom Center related business purpose. Employees must not disclose any confidential information, purposefully or inadvertently through casual conversation, or to any unauthorized person inside or outside Freedom Center. Employees who are unsure about the confidential nature of specific information must ask the Executive Director for clarification. Employees will be subject to appropriate disciplinary action, up to and including dismissal, for knowingly revealing information of a confidential nature.

It is the policy of Freedom Center for Independent living (Freedom Center) to keep all Consumers' information confidential. Discussion of Consumer information outside the office is forbidden and grounds for dismissal. The only reason information may be discussed in the office is to have authorized colleagues offer suggestions regarding issues with which an employee may be concerned and to better serve the Consumer.

\_\_\_\_\_  
Signature of Freedom Center Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Consumer's Signature

\_\_\_\_\_  
Date

**Freedom Center for Independent Living, Inc.  
WRITTEN GOAL PLAN**

**First Name** \_\_\_\_\_ **Last Name** \_\_\_\_\_

<b>IL PLAN</b> (704 Req.)	<input type="checkbox"/> Waived	<b>Goal Outcome:</b> (704 Req.)	<input type="checkbox"/> Ongoing
	<input type="checkbox"/> Accepted		<input type="checkbox"/> Achieved
<b>Date Defined:</b>		<b>Outcome Date:</b> (704 Req.)	<input type="checkbox"/> Dropped
<b>Goal Category:</b>	<input type="checkbox"/> Communication	<input type="checkbox"/> Mobility	
	<input type="checkbox"/> Consumer Rights	<input type="checkbox"/> Other	
	<input type="checkbox"/> Education & Training	<input type="checkbox"/> Personal Assistance	
	<input type="checkbox"/> Employment/Vocational	<input type="checkbox"/> Self-Care/IL Skills	
	<input type="checkbox"/> Equip/Assistive Devices	<input type="checkbox"/> Self-Help/Personal Growth	
	<input type="checkbox"/> Finance/Benefits	<input type="checkbox"/> Social/Recreation	
	<input type="checkbox"/> Health Care/Nutrition	<input type="checkbox"/> Transportation	
	<input type="checkbox"/> Housing		

**Goal Type:**  
Housing

**Goal Notes:**

**Goal Action Worksheet**

1. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

<b>Start Date</b> _____	<b>Anticipated Completion Date</b> _____	<b>Completion Date</b> _____
<b>Person Responsible:</b>	Consumer <input type="checkbox"/> Staff <input type="checkbox"/> Consumer & Staff <input type="checkbox"/> Other <input type="checkbox"/>	

2. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

<b>Start Date</b> _____	<b>Anticipated Completion Date</b> _____	<b>Completion Date</b> _____
<b>Person Responsible:</b>	Consumer <input type="checkbox"/>	Staff <input type="checkbox"/>
	Consumer & Staff <input type="checkbox"/>	Other <input type="checkbox"/>

3. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

<b>Start Date</b> _____	<b>Anticipated Completion Date</b> _____	<b>Completion Date</b> _____
<b>Person Responsible:</b>	Consumer <input type="checkbox"/>	Staff <input type="checkbox"/>
	Consumer & Staff <input type="checkbox"/>	Other <input type="checkbox"/>

4. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

<b>Start Date</b> _____	<b>Anticipated Completion Date</b> _____	<b>Completion Date</b> _____
<b>Person Responsible:</b>	Consumer <input type="checkbox"/>	Staff <input type="checkbox"/>
	Consumer & Staff <input type="checkbox"/>	Other <input type="checkbox"/>

Consumer Signature \_\_\_\_\_ Date \_\_\_\_\_

Staff Signature \_\_\_\_\_ Date \_\_\_\_\_

<b>FUNDERS</b>	Fee for Service	PVA	Transportation
DHOH/Dane Co	ILS/DHFS	SAP	USF
DHOH/United Way	ILS/RSA	SILC/Youth	WisLoan
Donations	ILS/	SSDI-EP	WisTech
ILS/United Way	Part D	Telework	





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Signature of Parent/Guardian (if applicable) \_\_\_\_\_ Date: \_\_\_\_\_

Witness/ Agency Representative \_\_\_\_\_ Date: \_\_\_\_\_

**Consent for Release of Information: Page 2**

\_\_\_\_\_  
Person's Full Name

Violation of Federal Law by a program is a crime. Suspected violations may be reported to the United States Attorney in the district where the violation occurs.

**TO ALL AGENCIES RECEIVING INFORMATION DISCLOSED AS  
A RESULT OF THIS SIGNED CONSENT:**

1. If the records released include information of any diagnosis or treatment or drug or alcohol abuse, the following statement applies:

Information disclosed pursuant to this consent has been disclosed to you for records whose confidentiality is protected by Federal Law.

Federal regulations (42 CFR Part 2) prohibit you from making any future disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

2. If the records released include information on an HIV - related diagnosis or test results, the following statement applies:

This information had been disclosed to you from confidential records protected from disclosure by state law. You shall make no future disclosures of this information without the specific, written and informed release of the individual to whom it pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is NOT sufficient for the purpose of the release of HIV test results or diagnoses.

3. This information has been disclosed to you from records protected by federal and/or state confidentiality rules. Any further release of it is prohibited unless the person to whom it pertains, Juvenile Court/DYS in the case of Youth records, or applicable federal and/or state law expressly permits the further disclosure.

# **Client Assistance Program**

## **NEW CASTLE COUNTY**

United Cerebral Palsy Center  
700-A River Road, Wilmington, DE 19809  
(302) 764-6216; (800) 640-9336; Fax (302) 764-6218

## **KENT & SUSSEX COUNTIES - MAIN OFFICE**

3249 Midstate Road, Felton, DE 19943  
{302}335-3739  
Fax(302)335-5716

**CAP is a place to turn to with questions or problems about rehabilitation programs.**

**What Rights Do I Have As A Vocational Rehabilitation Client?**

**CAP provides:**

- Information on available services from such providers as Vocational Rehabilitation, Division for the Visually Impaired, Centers for Independent Living, Independent Living Inc., other agencies providing rehabilitation services, and ADA - Title 1.
  - Information about your rights and responsibility as an applicant or client of the rehabilitation agencies.
  - Information services about Vocational Rehabilitation Services and Benefits.
  - Information/Referral
  - Assistance with resolving any concerns that you may have while seeking or receiving rehabilitation services.
- Help pursuing appeals or other legal remedies to ensure protection of your rights under the Rehabilitation Act.

**You have the right to:**

- Apply or reapply for vocational rehabilitation services. This includes the right to an evaluation to find out if you are eligible for services.
- Be involved in planning your own rehabilitation program.
- Be consulted about changes in, or decisions about, your program.
- Appeal decisions with which you do not agree.

**All services of CAP are free of charge & are provided on a non-discriminatory basis.**





# Freedom Center for Independent Living MEDIA RELEASE FORM

I, \_\_\_\_\_, grant permission to Freedom Center for Independent Living Inc, to use my image (photographs and/or video) for use in Media publications including:

(Check All That Apply)

- Videos  Photography  Recruiting Brochures  Newsletters  Magazines   
General Publications  Website and/or Affiliates  Email Blasts  
 Social Media  Other: \_\_\_\_\_

I hereby waive any right to inspect or approve the finished photographs or electronic matter that may be used in conjunction with them now or in the future, whether that use is known to me or unknown, and I waive any right to royalties or other compensation arising from or related to the use of the image.

Please **initial** the paragraph below which is applicable to your present situation:

\_\_\_\_\_ - I am 18 years of age or older and I am competent to contract in my own name. I have read this release before signing below, and I fully understand the contents, meaning and impact of this release. I understand that I am free to address any specific questions regarding this release by submitting those questions in writing prior to signing, and I agree that my failure to do so will be interpreted as a free and knowledgeable acceptance of the terms of this release.

\_\_\_\_\_ - I am the parent or legal guardian of the below named child. I have read this release before signing below, and I fully understand the contents, meaning and impact of this release. I understand that I am free to address any specific questions regarding this release by submitting those questions in writing prior to signing, and I agree that my failure to do so will be interpreted as a free and knowledgeable acceptance of the terms of this release.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Name (please print): \_\_\_\_\_

Address: \_\_\_\_\_

Signature of parent or legal guardian: \_\_\_\_\_  
(if under 18 years of age)

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**Peer Support Group Membership Application**

**Purpose:** To provide opportunities for socialization, peer-support, and peer-counseling for persons with disabilities as they work toward and/or maintain an independent lifestyle within their community. Peers tend to serve as excellent role models, often providing the motivation in others to envision the possibilities and develop the strategies to obtaining those visions. Information, one-on-one peer mentoring, and group interactions helping people with disabilities develop mutual support, assistance, and understanding.

Consumer Name: \_\_\_\_\_ Date \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Telephone Number(s) \_\_\_\_\_ Type: \_\_\_\_\_

Email Address(es): \_\_\_\_\_

Best Contact Method: Phone  Fax:  E-mail:  Mail:  Other:

Describe your experience/background related to persons with disabilities. (i.e., a person with a disability, a parent or family member of a person with a disability, professional, educator, etc.)

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Please describe the reasons for your interest in becoming a Peer Support Group member and what you hope to contribute to the group.

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What are some areas that you would be interested in as a Peer Support Group Meeting Topic, Independent Living Skills Training, or just something you are interested in learning more about?

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Thank you for your interest in becoming a Peer Support Group member!  
Please feel free to contact us if you need additional information or would like to discuss your possible membership.