

# DDD INTAKE FOR ASSISTIVE TECHNOLOGY SERVICES ADVANCING OPPORTUNITIES

Initial       Update

Program Type:     DDD--Regional     DDD--HR     DDD--RLC

**CONSUMER INFORMATION**

DDD ID #: \_\_\_\_\_ Referral Date: \_\_\_\_\_

Name: \_\_\_\_\_ Gender:  Female     Male    D.O.B.: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Street Address: \_\_\_\_\_ County: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ E-Mail: \_\_\_\_\_

Home #: ( ) \_\_\_\_\_ Work #: ( ) \_\_\_\_\_ Cell #: ( ) \_\_\_\_\_

Living with: \_\_\_\_\_ Relation to client: \_\_\_\_\_ Work #: ( ) \_\_\_\_\_

Living Arrangement: ( ) Own Home ( ) Family Care ( ) Skill Development ( ) Other \_\_\_\_\_  
(specify)

**Primary Disability:**

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> AIDS                          | <input type="checkbox"/> Blind                  | <input type="checkbox"/> Hard of Hearing     | <input type="checkbox"/> Spina Bifida       |
| <input type="checkbox"/> Amputee                       | <input type="checkbox"/> Carpal Tunnel Syndrome | <input type="checkbox"/> Head Injury         | <input type="checkbox"/> Spinal Cord Injury |
| <input type="checkbox"/> Amyotrophic Lateral Sclerosis | <input type="checkbox"/> Cerebral Palsy         | <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Arthritis                     | <input type="checkbox"/> Cystic Fibrosis        | <input type="checkbox"/> Mental Illness      | <input type="checkbox"/> Verbally Impaired  |
| <input type="checkbox"/> Asthma                        | <input type="checkbox"/> Deaf                   | <input type="checkbox"/> Mental Retardation  | <input type="checkbox"/> Visually Impaired  |
| <input type="checkbox"/> Autism                        | <input type="checkbox"/> Dyslexia               | <input type="checkbox"/> Multiple Sclerosis  | <input type="checkbox"/> Other:             |
| <input type="checkbox"/> Back Pain/Injury              | <input type="checkbox"/> Epilepsy               | <input type="checkbox"/> Muscular Dystrophy  |   |
|  |   | <input type="checkbox"/> Scoliosis           |   |

DDD CASE MANAGER / SUPPORT COORD: \_\_\_\_\_ Phone #: ( ) \_\_\_\_\_

- Check  Regional Office:
- |                      |   |   |
|----------------------|---|---|
| Northern Region      | <input type="radio"/> Flanders (Morris, Sussex & Warren Counties) | <input type="radio"/> Paterson (Bergen, Hudson & Passaic Counties)                            |
| Upper Central Region | <input type="radio"/> West Orange (Somerset & Union Counties)     | <input type="radio"/> Newark (Essex County)   |
| Lower Central Region | <input type="radio"/> Trenton (Mercer & Middlesex Counties)       | <input type="radio"/> Freehold (Ocean & Monmouth Counties)                                    |
| Southern Region      | <input type="radio"/> Voorhees (Burlington & Camden Counties)     | <input type="radio"/> Hammonton (Atlantic, Cape May, Cumberland, Gloucester & Salem Counties) |

Or Other Address (List complete address) \_\_\_\_\_

**CONTACT PERSON** is:       "Living With" (see above)     Case Manager/Support Coord. (see above),

Or  Other: \_\_\_\_\_ Title: \_\_\_\_\_

*If Other ( i.e. group home manager, ATC Staff, etc.), please complete the following:*

Agency: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Work #: ( ) \_\_\_\_\_ Fax#: ( ) \_\_\_\_\_ Cell #: ( ) \_\_\_\_\_ E-Mail: \_\_\_\_\_

**REASON FOR REFERRAL:** \_\_\_\_\_

**Intake Person:** \_\_\_\_\_ **Primary Staff Contact:** (referral assigned to) \_\_\_\_\_

Entered in ATS Database    Date Entered: \_\_\_\_ / \_\_\_\_ / \_\_\_\_    Data Entry Initials \_\_\_\_\_    IND# \_\_\_\_\_