

### DDD INTAKE RECORD

Individual's Name (*Last, First, M.I.*): \_\_\_\_\_ Date: \_\_\_\_\_

Address (*No., Street, City, State, ZIP*): \_\_\_\_\_

Phone Number: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Birthplace: \_\_\_\_\_

Sex:    Male        Female        Monthly Income: \_\_\_\_\_

Person or Agency Requesting Service: \_\_\_\_\_

Individual is Known to Following Agencies: \_\_\_\_\_

Presenting Problem:

FOLD HERE

### DDD INTAKE RECORD

Case Plan:

Follow-Up:

Final Case Status: \_\_\_\_\_

Intake Worker's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Supervisor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Equal Opportunity Employer / Program • Auxiliary aids and services are available upon request to individuals with disabilities • To request this document in alternative format or for further information about this policy, contact the Division of Developmental Disabilities Customer Service Center at 1-844-770-9500; TTY/TDD Services: 7-1-1

TRIM ALONG LINE

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