

Gender: _____

Marital Status: _____
Code

Marital Status

1	Never married
2	Married
3	Married legally separated
4	Divorced
5	Widowed
6	Married living apart
9	Unknown

Race: _____
Code

Race

1	White/Caucasian
2	Black/African American
4	Asian/Pacific Islander
5	Alaskan Native
6	American Indian
7	Multiracial
8	Decline to answer
U	Unknown
9	Other

Hispanic Origin: _____
Code

Hispanic Origin

1	Cuban
2	Mexican
3	Puerto Rican
5	Hispanic – specific origin unknown
6	Other Hispanic
7	Not Hispanic
8	Declined to answer
9	Unknown

US Citizenship: ___ Yes ___ No

Veteran Status: ___ Yes ___ No ___ Unknown

Days of Paid Work in Past 30 Days _____

Employment Status: _____
Code

Employment Status

1	Employed full time (35+/wk)
2	Employed part time (< 35/wk)
N	Unemployed - seeking
3	Not in labor force –homemaker
4	Not in labor force – student
5	Not in labor force – retired
6	Not in labor force – disabled
7	Not in labor force – institution
8	Not in labor force – child
9	Not in labor force – other (not seeking)
P	Employment Program
U	Unknown

Referral Source: _____
Code

Referral Source

1	Self
2	Family or friend
5	Employer/EAP
10	School system/Educational agency
11	Police/Sheriff
12	Court - Other
13	Juvenile & Domestic Court
14	General District Court
17	DRS (MR)
26	Local correctional facility
27	CDI
28	ASAP/DUI
29	State correctional facility 3
30	Private MH OP provider
31	State MH Outpatient Provider
32	CSB MH Program
33	Infant/toddler connection
34	CSB MR Program
36	CSB AD Program
37	State MH facility
38	State MR facility other
39	MR care provider
40	Private hospital
41	Private physician
42	OT/PT/Speech Therapist
44	Non hospital SA care provider
50	State institution NVTC (MR)
51	State institution CVTC (MR)
60	Managed care org. (HMO)
65	County Unified Intake
75	Probation
76	Parole
81	Health Department
87	Housing and Community Dev.
88	DHD/DSS APS
89	DHD/DSS CPS
90	DHD/DSS Foster Care
91	DHD/DSS other (not TANF)
92	DHD/DSS - TANF CW
95	Other VA CSB
98	Unknown
99	Other community referral

Special Education: ___ Yes ___ No

If yes, date of graduation: ____/____/____

Education Level _____
Code

Education Level

1	Never attended school
3	Preschool/Kindergarten
4	Grade 1-7
5	Completed 8 th Grade
10	Some HS or vocational education
15	Completed HS or vocational education
20	Some college (<4 yrs)
30	Completed college (4 + yrs)
98	Unknown

Physical Disability (Check all that apply):

- Deafness or severe hearing loss
- Inability to communicate verbally
- Seizure Disorder
- Declined to answer
- Blindness or severe visual impairment
- Traumatic head injury
- Cerebral Palsy
- Unknown
- Non/Difficulty in ambulation
- Major medical/chronic health problems
- None
- Other

Primary Language _____ Code _____

Primary Language

1	English
2	Spanish
3	French
4	German
5	Indochinese
6	Farsi
7	Gestures
8	American Sign
9	Other language

LEGAL/COURT/GUARDIANSHIP:

Please describe any criminal history or legal/court involvement: _____

Type of Guardianship:
 Full/Conservator Partial Guardian Partial Conservator None

If other than none, please indicate the Guardianship Status (select one):

<input type="checkbox"/> For minor: parents	<input type="checkbox"/> For adult: own guardian
<input type="checkbox"/> For minors: CPS	<input type="checkbox"/> For adult: guardian of estate
<input type="checkbox"/> For minor: emancipated	<input type="checkbox"/> For adult: guardian of person
<input type="checkbox"/> For minor: court	<input type="checkbox"/> For adult: guardian of estate/person
<input type="checkbox"/> For minor: other	<input type="checkbox"/> For adult: limited guardian
<input type="checkbox"/> Guardianship recommended	<input type="checkbox"/> Power of attorney
<input type="checkbox"/> Court is legal guardian/conservator	<input type="checkbox"/> For adult: other

Date Guardianship Awarded ____/____/_____

Relationship of (Primary) Guardian (select one):

<input type="checkbox"/> Siblings	<input type="checkbox"/> Other relative
<input type="checkbox"/> Father	<input type="checkbox"/> Other non-relative
<input type="checkbox"/> Mother	<input type="checkbox"/> Parents / Stepparents
<input type="checkbox"/> Spouse	<input type="checkbox"/> Other
<input type="checkbox"/> Child	<input type="checkbox"/> Self

RELATIONSHIPS:

For the following relationships table, please indicate significant others of the applicant, including parents and/or any other primary caregivers, emergency contacts, guardians, and representative payees for benefits. For each individual, fill in the name, relationship to the applicant, address and phone numbers (if different than applicant), date of birth, and whether or not they are a primary caregiver, emergency contact, guardian and/or benefits payee. **For primary caregivers, please indicate their health status using one of the following descriptors: Life threatening, poor, fair, good, or excellent.**

RELATIONSHIPS

Name & Relationship	Address & Phone Numbers	Date of Birth	Primary Caregiver?	Emergency Contact?	Guardian?	Benefits Payee?
			Yes No If yes, indicate Health Status:	Yes No	Yes No	Yes No
			Yes No If yes, indicate Health Status:	Yes No	Yes No	Yes No
			Yes No If yes, indicate Health Status:	Yes No	Yes No	Yes No
			Yes No If yes, indicate Health Status:	Yes No	Yes No	Yes No
			Yes No If yes, indicate Health Status:	Yes No	Yes No	Yes No

FINANCIAL/INSURANCE:

Applicant's Gross Annual Income \$_____

Number of Dependents:_____

Insurance Company Name:_____

Policy Number:_____

Printed Name of Person Completing the Application

Relationship to Applicant

Telephone

Signature of Person Completing the Application

Date

In order to expedite the intake process, please gather and attach the following documentation to this intake application:

1. Reports of psychological evaluations and/or developmental evaluations
2. School records, such as a Social History, Individualized Education Plan, Basis for Committee Decision
3. Other professionals' supporting documentation of disability

Please mail this completed application and all supporting documentation to the following address:

Mental Retardation Services
Attn: Intake Case Manager
12011 Government Center Parkway
Suite 300
Fairfax, Virginia 22035

Upon receipt of the intake application, an Intake Case Manager will contact you to answer any questions you may have, and to coordinate obtaining any further documentation needed. If you do not hear from our agency within two weeks, please call 703-324-4400 and request to speak with an Intake Case Manager.