

Intake social history

Form 824-I

Version Date: February 2026

PRIVACY NOTICE: The information you provide will be used to determine eligibility for division services. It will only be used by DHHS and, if needed, by individuals or parties contracted with DHHS. Without this data, we cannot make a determination. This data is part of record series: 15376.

Date:

Completed by:

Applicant's personal information

Legal name (first, middle, last):

Preferred name:

Date of birth:

Sex:

Primary language:

Communication/translation need:

None required

Spoken language

Signed language

AA

TTY

Race and ethnicity:

American Indian or Alaska Native

Black or African American

Asian

Hawaiian Native or Other Pacific Islander

Hispanic, Latino/a/x, or Spanish Origin

Multi-Race

Middle Eastern or North African

Non Hispanic, Latino/a/x, or Spanish Origin

White

Prefer not to say

Prefer to self-describe

Guardianship status:

Own guardian

Biological parent

Adoptive parent

Youth in care

Guardian

Marital Status:

Single

Married

Divorced

Domestic partnership

Widowed

Applicant's contact information

Physical address: City: UT Zip code:

Mailing address: City: UT Zip code:

Phone number: Email:

Is the Applicant the primary contact for information? Yes No

Important people to contact

Please list no more than 3 people to act as primary and emergency contacts. Include parents and legal guardians if applicable, and at least one individual who does not live with the Applicant. Legal guardians must provide a copy of their guardianship papers.

Contact one

Lives with Applicant? Yes No Primary contact

Name: Relationship to Applicant:

Address: City: State: Zip code:

Phone number: Email: Primary language:

Communication assistance: None required Spoken language Signed language AA TTY

Contact two

Lives with Applicant? Yes No Primary contact

Name: Relationship to Applicant:

Address: City: State: Zip code:

Phone number: Email: Primary language:

Communication assistance: None required Spoken language Signed language AA TTY

Contact three

Lives with Applicant? Yes No Primary contact

Name: Relationship to Applicant:

Address: City: State: Zip code:

Phone number: Email: Primary language:

Communication assistance: None required Spoken language Signed language AA TTY

Applicant's education history

Please list the current or last school attended.

Name of school: Type of school:

School contact information:

Does/did the Applicant receive early intervention services? Yes No

Does/did the Applicant receive special education services? Yes No

If still in school, what date will the Applicant graduate or transition out?

Applicant's employment history

For Applicants aged 16 years and older, please list their most recent job.

Employer: Part-time Full-time

Start date: End date: Hours per week: Hourly wage:

Job title/description:

Type of employment (please check one):

Integrated Individual Employment (e.g. Applicant has/had own job in the community)

Integrated Work Crew (e.g. Applicant works/worked in the community on a work crew)

Facility-Based (i.e. participated in a sheltered workshop, work activity, etc.)

Work related issues (i.e. any difficulties that affected job performance):

Work related successes, special skills, etc.:

Previously received Supported Employment through Vocational Rehabilitation? Yes No

If yes, what year did the Applicant receive employment services?

Is the Applicant seeking employment that requires ongoing support? Yes No

Does the Applicant currently have an open case with Vocational Rehabilitation? Yes No

If yes, which office: Office phone number:

Areas of concern

List any major health (physical, psychological, substance abuse, etc.) concerns, and the related diagnoses that affect the Applicant's life.

Behavioral health

Receiving support?	Yes	No
Need support?	Yes	No

If need support, please describe.

Substance use

Receiving support?	Yes	No
Need support?	Yes	No

If need support, please describe.

Mental health

Receiving support?	Yes	No
Need support?	Yes	No

If need support, please describe.

Safety

Receiving support?	Yes	No
Need support?	Yes	No

If need support, please describe.

Physical health

Receiving support?	Yes	No
Need support?	Yes	No

If need support, please describe.

Other

Receiving support?	Yes	No
Need support?	Yes	No

If Need support, please describe.

Brain injury

Does the Applicant have a brain injury? Yes No

 Did the brain injury occur pre or post birth? Pre Post

 Date the brain injury occurred:

 Describe the cause of the brain injury.

Applicant's medical/specialized equipment

Does the Applicant use any specialized equipment (e.g. wheel chair, walker, g-tube, ventilator, etc.)? Yes No

If yes, please describe the specialized equipment used.

Applicant's recent hospitalizations

List any hospitalizations within the last year, including psychiatric care and in-patient residential treatment.

Facility name

Reason for admission

Admission date

Discharge date

Facility name

Reason for admission

Admission date

Discharge date

Nursing Facility or Intermediate Care Facility (ICF)

Is the Applicant now, or have they ever been a resident of a Nursing Facility? Yes No

Facility Name Admission Date Discharge Date

Is the Applicant now, or have they ever been a resident of an intermediate care facility (ICF)? Yes No

Facility name Admission date Discharge date

Other agency involvement

If the Applicant is involved with any other city, state, or federal agencies, fill out the following information.

Agency name	Agency name
Contact person	Contact person
Phone number	Phone number
Email	Email

Applicant's professional relationships

List any significant professionals (e.g. doctors, school representatives, therapists, service providers, etc.).

Type of professional	Type of professional
Name	Name
Phone number	Phone number
Email	Email

Court orders

If the Applicant is currently affected by any court orders, list the order below and provide a copy.

Order type: _____ Date signed: _____

Order type: _____ Date signed: _____

Order type: _____ Date signed: _____

Applicant's benefits

If the Applicant receives any financial benefits, fill out the following information.

Benefit type

Benefit type

Amount

Amount

Frequency received

Frequency received

Applicant's health insurance

Choose all that apply.

Medicaid Identification number: _____

Medicare Identification number: _____

Private insurance: _____