Department of Health & Human Services | Services for People with Disabilities

Intake social history

Form 824-I
Version Date: April, 2025

PRIVACY NOTICE: The information you provide on this form will be used to determine eligibility for division services. It will be used only by DHHS, if needed, or by a person or party contracted with DHHS. Without this information, we cannot make a determination about your eligibility. 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 person 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 receiving services from 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 current professionals (e.g. doctors, school representatives, therapists, service providers, etc.).

Type of professional _____ Name _____

Name _____ Phone number _____

Phone number _____ Email _____

Email _____

Type of professional _____

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

Amount

Frequency received

Benefit type

Amount

Frequency received

Applicant's health insurance

Choose all that apply.

- ☐ Medicaid Identification number:
- ☐ Medicare Identification number:
- ☐ Private insurance: