

BEXAR MRA
8700 Tesoro Drive, Suite 700
San Antonio, TX 78217

INTAKE AND ELIGIBILITY
APPLICATION

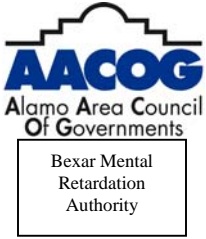
**DOCUMENTS TO BRING TO YOUR
INTAKE APPOINTMENT**

The following documents are required to be brought in at the time of the Intake appointment.

- Proof of Residency verifying the consumer resides in Bexar Co.
- Proof of Income must be provided at the time of the intake appointment. If the consumer is under the age of 18, proof of the family income must be provided. If the consumer is over the age of 18, proof of their income must be provided. (income tax return or W2, if income tax was not filed then 3 months of current pay stubs, current SSI award letter)
- Special Education Testing from the School District(s) attended by the consumer (the Full and Individual Evaluation)
- Doctor’s Letter, previous Psychological evaluations or assessments
- Social Security Card
- Birth Certificate
- Insurance Information (Private Insurance Card, or Medicaid Letter)
- Health/Medical Information
- Any other Legal documents (Conservatorship Order, Letters of Guardianship, Adoption papers, Divorce Decree, Custody papers, etc.)

*Also, please complete as much of the information on the attached as possible.
This will assist us in completing your appointment quickly.*

***If you have any questions, or need special accommodations for your appointment
(E.g. interpreting services, assistive listening devices, or wheelchair accommodations)
please contact us at (210) 832-5020***



**MENTAL RETARDATION
INTAKE AND ELIGIBILITY**

**8700 Tesoro Drive
Suite 700
San Antonio, Texas 78217
(210) 832-5020**

Consumer Name: _____

Case #: _____

Program/Unit: _____

Sub Unit #: _____

**Determination of Mental Retardation
Demographic Information**

Individual's Name: _____ Age (Years/Months): ____/____ DOB: ____/____/____

Social Security Number _____ Federal Race _____ Ethnic Heritage _____

Parent/Guardian Information:

Parent/Guardian Name _____ Relationship to Consumer _____

Parent/Guardian Address _____

Parent/Guardian Phone Number _____ Alternate Phone Number _____

Emergency Contact Name _____ Relationship to Consumer _____

Emergency Contact Address _____

Financial Information:

Monthly

Consumer Employment	\$ _____	Child Support	\$ _____
Supplemental Security Income (SSI)	\$ _____	Food Stamps	\$ _____
Social Security Disability Insurance (SSDI)	\$ _____	Retirement	\$ _____
Social Security	\$ _____	Unemployment	\$ _____
Parents	\$ _____	Extraordinary Expenses	\$ _____
Other	\$ _____	List Extraordinary Expenses	_____
Total Monthly Income	\$ _____		

Insurance Information:

Insurance Company Name	Effective Date	Expiration Date	Policy ID Number

Consumer Name: _____

Case #: _____

**Determination of Mental Retardation
Health/Social Information**

Today's Date: ____/____/____

Individual Age (Years/Months): ____/____

DOB: ____/____/____

Name(s) of Person(s) Providing Information: _____

Relationship to the Individual: _____

Health

Please give names of the Individual's physician or any other doctors:

Primary Care: _____

Psychiatrist: _____

Neurologist: _____

Other M.D.s: _____

List any known Allergies (all types): _____

Medications: ____NONE

Individual's Height ____ ft. ____ in

Weight ____ lbs.

<u>Medication</u>	<u>How Often</u>	<u>Reason</u>

Physical/Sensory Limitations:

Please Check one

Visually Impaired	Spasticity	Other:
Blind	Walking Aid (Cane, Walker)	Other:
Deaf	Wheelchair	Other:
Speech Impairment	Non-verbal	Other:
Paraplegia (Paralysis of legs and lower body)	Quadriplegia (Paralysis of both arms and legs)	Hemiparesis (affecting only one side of the body)

Consumer Name: _____

Case #: _____

Mental Health

Hallucinations: ___None ___ Auditory ___ Visual ___ Tactile ___ Delusions

Is there any Family History of Mental Illness? If so please check below and indicate the relationship to the Individual

<input type="checkbox"/>	None Reported	<input type="checkbox"/>	Affective Disorder,
<input type="checkbox"/>	Mental Retardation,	<input type="checkbox"/>	Illicit Drug Abuse,
<input type="checkbox"/>	Autism/PDD,	<input type="checkbox"/>	Prescription Drug Abuse,
<input type="checkbox"/>	Childhood Disorders,	<input type="checkbox"/>	Alcohol Abuse,
<input type="checkbox"/>	ADHD,	<input type="checkbox"/>	Other,
<input type="checkbox"/>	Psychosis,	<input type="checkbox"/>	Other,

Social Information

Family/Significant Relationships/Others in Home (note if siblings are full, half or step):

Biological Father:

Name: _____ Medical Info: _____

Age: _____ Currently: ___ Living ___ Deceased ___ Living in the home ___ Not in the Home

Biological Mother:

Name: _____ Medical Info: _____

Age: _____ Currently: ___ Living ___ Deceased ___ Living in the home ___ Not in the Home

Sibling: (Brother or Sister)

Name: _____ Medical Info: _____

Age: _____ Currently: ___ Living ___ Deceased ___ Living in the home ___ Not in the Home

Sibling: (Brother or Sister)

Name: _____ Medical Info: _____

Age: _____ Currently: ___ Living ___ Deceased ___ Living in the home ___ Not in the Home

Sibling: (Brother or Sister)

Name: _____ Medical Info: _____

Age: _____ Currently: ___ Living ___ Deceased ___ Living in the home ___ Not in the Home

Other:

Name: _____ Medical Info: _____

Age: _____ Currently: ___ Living ___ Deceased ___ Living in the home ___ Not in the Home

Consumer Name: _____

Case #: _____

Pregnancy History

Birth Order: Individual is an only child _____

Individual is _____ of _____ children (Ex. Individual is 1 of 4 children.) Individual is the _____ child.
Number Total number Number

Total number of pregnancies for the mother _____ Miscarriages _____

Total number of children living _____. Total number of children deceased _____.

Check if any of the following were used during the pregnancy: List name

Alcohol _____	Illegal Drugs _____
Prescription Medications _____	Cigarettes _____
Over-the-counter Medications _____	No Alcohol or Drugs _____

Normal Pregnancy ____ Full Term ____ Normal labor ____ Normal Delivery ____ Cesarean Section ____

Premature ____ Number of weeks Premature _____ Adopted ____ Unknown ____

Prenatal Complications: _____

Length of stay in Hospital _____ Birth Weight _____ pounds, _____ ounces

Developmental Milestones:

Milestone	Age (month/year)	Milestone	Age (month/year)	Milestone	Age (month/year)
Rolled over		Finger-fed self		Toilet-trained	
Sitting up		Spoon-fed self			
Crawled		Single words			
Walked		Sentences			

Not Ambulatory _____ Non-Verbal _____

Not Yet Toilet Trained _____ Partially Toilet Trained _____

Toileting Accidents: Day _____ Night _____ Frequency: _____

Diagnostic History:

(Please give doctor's name and date diagnosis was made.)

Diagnoses at Birth: ____ None

____ Mental Retardation _____

____ Autism _____

____ Pervasive Developmental Disorder (PDD) _____

____ Downs Syndrome _____

____ Cerebral Palsy _____

____ Seizures (Type, frequency, first & most recent occurrence) _____

____ Other Diagnoses or Health Problems _____

Previous Medical Doctors? (For what, where, when and by whom?) _____

Consumer Name: _____

Case #: _____

Diagnostic History Continued

Previous Hospitalizations? (For what, where and when?) _____

Previous Psychiatric or Mental Health Treatment? (For what, where, when and by whom?) _____

Suspected Cause of MR &/or Related Condition _____

School History:

Currently enrolled in the following school: _____ School District: _____

Not in school _____ Graduated (School): _____ Withdrew (Reason): _____

Enrolled in Special Education Services for the following reason: ___ Mental Retardation, ___ Autism, ___ Orthopedic Impairment, ___ Speech Impairment, ___ Hearing Impairment/Auditory Impairment, ___ Visual Impairment, ___ Other Health Impairment, ___ Learning Disabled, ___ Emotional Disturbance, ___ Other (give reasons) _____

Enrolled in the following educational programming: (Check those that apply)

<input type="checkbox"/>	Regular Classes	<input type="checkbox"/>	Counseling
<input type="checkbox"/>	Physical Therapy	<input type="checkbox"/>	Daily Living Skills
<input type="checkbox"/>	Prevocational Training	<input type="checkbox"/>	Behavior Management
<input type="checkbox"/>	Occupational Therapy	<input type="checkbox"/>	Vocational Training
<input type="checkbox"/>	Speech Therapy	<input type="checkbox"/>	Other

Previous Schools _____

Previous Services for Mental Retardation (please include where, when, what did and for how long)

Vocational History (please include where, when, what did and for how long) _____

Signatures

Individual's Signature

Date

Legally Authorized Representative

Date

Mental Retardation Care Specialist

Date