



# Human Services Department

Wyandotte County

Developmental Disabilities Organization

701 North 7<sup>th</sup> St., Rm: 346

Kansas City, KS 66101

PH: (913) 573-5502

Fax: (913) 573-5511

WCDDO@wycokck.org

## Intake Form

(Please complete this form to its entirety and return to Yer Hang; [yhang@wycokck.org](mailto:yhang@wycokck.org).)

### **CONSUMER INFORMATION**

Full Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Current Wyandotte County address: \_\_\_\_\_

(City, State)

(Zip code)

Telephone number: \_(\_\_\_\_)\_\_\_\_\_ Alternate #: \_(\_\_\_\_)\_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Medicaid Number: \_\_\_\_\_

E-mail address: \_\_\_\_\_

### **GUARDIANSHIP INFORMATION** (Please check all that apply)

You (applicant) are a ward of the State.

SRS Case Worker Name: \_\_\_\_\_

SRS Office Location: \_\_\_\_\_ Telephone: \_(\_\_\_\_)\_\_\_\_\_

Foster Care/Adoption Case Worker Name: \_\_\_\_\_

Agency: \_\_\_\_\_ Telephone: \_(\_\_\_\_)\_\_\_\_\_

You (applicant) have a legal guardian.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

(city, State)

(zip code)

Telephone: \_(\_\_\_\_)\_\_\_\_\_

### **EMERGENCY CONTACT**

Full Name: \_\_\_\_\_

Telephone Number: \_(\_\_\_\_)\_\_\_\_\_ Alternate #: \_(\_\_\_\_)\_\_\_\_\_

Relationship: \_\_\_\_\_

## **DISABILITY INFORMATION**

Please indicate the type of disability you have been diagnosed with by a medical specialist

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*(for example: Intellectual Disability, Seizures, Cerebral Palsy)*

Name of medical professional that diagnosed you: \_\_\_\_\_

Name of medical facility you were seen: \_\_\_\_\_

Address: \_\_\_\_\_  
*(City, state)* *(zip code)*

Contact Number: \_\_\_\_\_

## **TRANSFER INFORMATION**

Please provide the facility information you are transferring from:

Name of facility: \_\_\_\_\_

Address: \_\_\_\_\_  
*(City, state)* *(zip code)*

Contact Person: \_\_\_\_\_  
*(Full Name)* *(Phone Number)*

What services have you been receiving? \_\_\_\_\_  
*(Full Name)* *(Phone Number)*

## **AUTHORIZING SIGNATURE**

*I authorize the use of disclosure of the records/information described. I have read and understand this form. I have received a copy of this form. I am the consumer listed or am authorized to act on behalf of the consumer as the consumer's personal representative. My signature below affirms that I have completed this application truthfully and that I have read and understand the confidentiality statement herein.*

**Consumer Signature:** \_\_\_\_\_  
*(full name)*

**Signature of person assisting consumer:** \_\_\_\_\_  
*(Relationship)*

**Date:** \_\_\_\_\_