Texas Department of Aging
and Disability Services

IHFSP Individual Supports Worksheet

Form 2349
June 2013-E

Individual Name	SSN	Interview Date

Section I – Caregiver/Informal Supports

Primary Caregiver	Relationship	Lives W/ Individual	Employed/In School	If so, number of hours/week
		☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	
Other Caregiver(S)/Relationship				

Other Supports (describe):

Section II Other Services Received (Check all that apply. Specify additional information where indicated.)

*Coordinate benefits per IHFSP if this service is received.

☐ ERS	☐ CCAD(PHC*/FC)	›	Hours Per Week
☐ AFC	☐ CMAS/Shared Att.	›	Hours Per Week
☐ Medicaid*	☐ Meals	›	Units Per Week
☐ Housing Assistance	☐ DAHS	›	Units Per Week
☐ Medical Transportation	☐ EPSDT/CCP*	›	Services Received
☐ Medicare	☐ CIDC	›	Services Received
☐ MQMB/QMB*	☐ DARS	›	Services Received
☐ SLMB*	☐ Medicare Supplement Insurance	›	Services Covered
☐ TANF*	☐ Other Private Insurance	›	Services Covered
☐ SNAP*	☐ Local Medical Asst. Program	›	Services Covered
☐ MDCP*	☐ Other (specify):	›	Services Received
	☐ Other (specify):	›	Services Received

Section III Interest Lists

☐ CLASS	Date on List:
☐ CBA	Date on List:
☐ SPW	Date on List:
☐ Other IL (specify)	Date on List:

Comments/Updates

Signature – Case Manager

Date