DISABILITY LAW COLORADO™
Protecting the rights of Coloradans of all ages since 1976

Disability Law Colorado Intake Form

Please complete all items below and return it to:
Disability Law Colorado
455 Sherman Street, Suite 130
Denver, CO 80203
dlcmail@disabilitylawco.org

Your Name:_____ **Your Phone #:**_____

Your Email:_____

If you are NOT the person with a disability, how do you know this person?_____

Legal Name of Person with a Disability:_____

Preferred name of Person with a Disability:

Date of Birth of Person with a Disability:_____

DOC or Patient ID Number (if applicable):_____

Street Address or Facility Name of Person with a Disability:_____

City:_____ **State:**_____ **Zip Code:**_____

County:_____

Phone Number (if applicable):_____ **Email:**_____

Disability(ies):_____

Gender:_____ **Ethnicity:**_____

Is the Person with a Disability a Veteran? ☐ ☐

Pronouns:_____ **Are you Registered to Vote?**_____

Does Person with a Disability receive SSI? ☐ **SSDI?** ☐

Who referred you to us? _____

Are you vaccinated? Yes ☐ **No** ☐

Does the person with a disability use assistive technology (for example, something that helps them speak, move, or breathe such as a cane, oxygen, recording device, communication board, wheelchair, prosthetic, etc.)? If so, please describe what assistive technology they use:

_____

Have you (or the person you are contacting us about) ever hit your head or been hit on the head?_____

Were you (or the person you are contacting us about) ever seen in the Emergency room, hospital, or by a doctor because of an injury to your head? _____

Did you (or the person you are contacting us about) ever Lose consciousness or experience a period of being dazed and confused because of an injury to your head?_____

Did you (or the person you are contacting us about) ever Lose consciousness or experience a period of being dazed and confused because of an injury to your head?_____

Do you or the person you are contacting us about experience any of these Problems in your daily life since you hit your head?

headaches ☐
dizziness ☐
anxiety ☐
depression ☐
difficulty concentrating ☐
difficulty remembering ☐
difficulty reading, writing, calculating ☐
poor problem solving ☐
difficulty performing your job/school work ☐
change in relationship with others ☐
poor judgment- being fired, fighting, arrests ☐

Have you or the person you are contacting us about had any significant sicknesses? _____

<u>Complaint Information</u>: *Please enter the following information about the person and/or agency, organization, or entity you are making this complaint against. This could be a school district, jail, store, Community Centered Board, restaurant, employer, housing provider, prison, etc. You should also include the name(s) and title(s) of any individuals you have had concerns with or talked to in an attempt to resolve the issues you are raising in your complaint.*

Name of Agency, Organization, or Entity:_____

Name(s) and Title(s) of Individual(s):_____

Street Address:_____

City:_____ State:_____ Zip Code:_____

Phone Number:_____

Date of Incident Giving Rise to Your Complaint:_____

<u>Please provide the below information for any attorney, advocate, or organization you and/or the person with a disability have worked with related to this issue</u>:

Name:_____Organization or Firm:_____

Street Address:_____

City:_____ State:_____ Zip Code:_____

Phone Number:_____

Please describe what this advocate, attorney, or organization has done for you that is related to your current complaint:_____

_____

_____

Are you currently working with this advocate, attorney, or organization?_____

If your complaint is regarding housing, do you live in private or public housing (Section 8, Subsidized, etc.)?_____

Complaint Description (use a separate page, if necessary):

Please describe IN DETAIL the events that lead you to file this complaint. This should include facts that explain the who, what, when, and where of the situation. Please include specific dates, as well as names and titles of involved individuals.

Please state clearly what you would like Disability Law Colorado to do for you:

Please describe any steps you have already taken to try to resolve your concerns. Please include (to the extent you know): names and titles of people you've spoken with; dates you spoke with them; and their response to your concerns.

Note: If you have filed a grievance regarding this issue, please provide a detailed description of the grievance procedure you followed on a separate page. If you have not yet done this, please see the attached information regarding grievance procedures.

☐ *Please check this box to indicate that the information you have provided is true and correct; that you understand that by accepting this complaint, Disability Law Colorado is not undertaking legal representation of you, and Disability Law Colorado is not responsible for ensuring that any statute of limitations requirement or any other requirement or deadline is met in your case.*

Thank you for participating in the intake process with Disability Law Colorado. We appreciate the time you took to speak with us about your concerns. We will review your intake with the attorneys who oversee our legal programs to determine whether we can assist you or if there is additional information or documentation they need from you prior to making that determination. In the meantime, it may be helpful for you to review the Fact Sheets on various topics that we have available on our website at http://www.disabilitylawco.org/resources/fact-sheets.