Application for Services Date:

Member Name:

Address:

Phone: Cell: E-mail:

Date of Birth: Gender: Ethnicity:

Social Security Number: Medicaid/State ID Number:

Diagnosis (primary): Diagnosis (secondary):

School: Education Level:

Any DCS involvement? Any legal issues?

Parent/Guardian Name:

Address:

Daytime Phone: Cell: E-mail:

Primary Funding Source: Algo Level:

Case Manager: Case Management Company:

List any accommodations needed:

Additional comments:

Signature of Member ____

Signature of Parent/Guardian____