**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

***(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:***