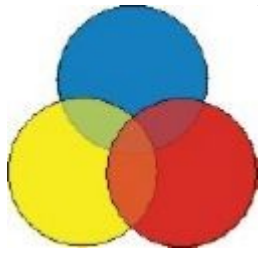


Consumer Name: _____ ID# _____ Medicaid#: _____ DOB: _____



No Bounds Care Inc.

“Making a Difference, One Family At A Time.”

Application for Admission- Community Support Team

Date of Application: _____ Time: _____ Record#: _____

Name: _____ Highest Grade Completed: _____

First: _____ Middle: _____ School Contact Person : _____

Last: _____

Also Known As (Nickname): _____ Legally Responsible Person: (please check one)

Maiden Name: _____ Guardian: _____ Next of Kin: _____

Address: _____ Name: _____

City/ Town: _____ City/ Town: _____

State: _____ Zip Code: _____ State: _____ Zip Code: _____

Phone# _____ Phone#: _____

(home) (work) (home) (work)

Date of Birth: _____ Who suggested you come to our agency?

Social Security# _____ Private Physician _____ Community Agency _____

County of Residence: _____ Family/ Friends _____ Court _____

Male: ___ Female: ___ Marital Status: _____

Race: _____ Self _____ School _____

Consumer Name: _____ ID# _____ Medicaid#: _____ DOB: _____

_____ White

None

_____ Other

_____ Black

_____ American Indian, Alaskan Native

_____ Asian

_____ Other: _____

Are you a Work First Referral? Yes ___ No ___

Preferred Physician to contact in the case of a n
emergency: _____

Ethnicity:

Reason for coming to our Agency:

_____ Not Hispanic

_____ Hispanic, Mexican America n

_____ Hispanic, Puerto Rica n

_____ Hispanic, Cuba n

_____ Hispanic, Other

List any known allergies / hypersensitive or dru g
allergies: _____

In the case of an emergency, contact:

Name: _____

Primary Language: English _____ Spanish _____

Relationship to consumer: _____

Other (specify) :

Address: _____

Interpreter Needed: Yes: _____ No: _____

City/ Town: _____

State: _____ Zip Code: _____

Insurance Company: _____

Phone#: _____

Policy Number: _____

Expiration Date: _____

Applicant / Guardian Signature / Date