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: _____

Name:

First: _____ Middle: _____

Last: _____

Also Known As (Nickname): _____

Maiden Name: _____

Address: _____

City/ Town: _____

State: _____ Zip Code: _____

Phone# _____ _____

(home) (work)

Date of Birth: _____

Social Security# _____

County of Residence: _____

Male: ___ Female: _____ Marital Status: _____

Race:

Record#: _____

Highest Grade Completed: _____

School Contact Person : _____

Legally Responsible Person: (please check one)

Guardian: _____ Next of Kin: _____

Name: _____

City/ Town: _____

State: _____ Zip Code: _____

Phone#:_____ _____

(home) (work)

Who suggested you come to our agency?

Private Physician ____ Community Agency____

Family/ Friends ____ Court ____

Self ____ School ____

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

____ White

____ Black

____ American Indian, Alaskan Native

____ Asian

____ Other: _____

Ethnicity:

____ Not Hispanic

____ Hispanic, Mexican American

____ Hispanic, Puerto Rican

____ Hispanic, Cuban

____ Hispanic, Other

Primary Language: English ____ Spanish _____

Other (specify) :

Interpreter Needed: Yes: ____ No: ____

Insurance Company: _____

Policy Number: _____

Expiration Date: _____

Applicant / Guardian Signature / Date

None ____ Other ____

Are you a Work First Referral? Yes ___ No___

Preferred Physician to contact in the case of an emergency: _____

Reason for coming to our Agency:

List any known allergies / hypersensitive or drug allergies: _____

In the case of an emergency, contact:

Name: _____

Relationship to consumer: _____

Address: _____

City / Town: _____

State: _____ Zip Code: _____

Phone#:_____