CAPE COUNTY BOARD FOR THE DEVELOPMENTALLY DISABLED

CLIENT REGISTRATION FORM

Please print clearly

FIRST NAME: _____ MIDDLE: _____

LAST NAME: _____ NICKNAME: _____

DATE OF BIRTH: _____ AGE: _____ MALE: ☐ FEMALE: ☐

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PHONE NUMBER: _____

Optional Information:

DOCTOR: _____ PHONE: _____

EMERGENCY CONTACT: _____ PHONE: _____

Consent to Release Information if you are a client of Catholic Charities. If you are not, please disregard it.

I, _____, give consent to Catholic Charities, to release information to Cape Girardeau County Transit as to whether I receive Support Coordination Services through their organization or not.

By signing below, I give Cape Girardeau County Transit Authority authorization to discuss and/or obtain documentation regarding my developmental, mental or physical health for the purpose of my SB40 application for transportation. I also understand that I have the right to revoke the consent at any time, and if I refuse to grant consent my application may not be approved without other supporting documentation which I must supply.

CLIENT/GUARDIAN SIGNATURE: _____ DATE: _____

PRINT NAME: _____

Catholic Charities:

I, _____, confirm that _____ DOES receive Support Coordination Services through our organization.

SUPPORT COORDINATOR SIGNATURE: _____ DATE: _____

CGCTA Office Use Only:

APPROVED BY: _____ DATE: _____