



Children with Special Health Care Needs

Application for Services

Person to Receive Services:

Name (Last, First Middle): _____ Date of Birth: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Home Phone: _____ Cell Phone: _____
 Work Phone: _____ E-mail: _____

Sex: Male Female

Ethnicity: Hispanic or Latino
 Non-Hispanic or Latino
 Declined

Race: White Black or African American American Indian or Alaskan Native
 Asian Native Hawaiian or Pacific Islander Other
 Declined

Languages Spoken in the Home:

Preferred Correspondence Method:

E-Mail
 Standard Mail

Parent Guardian Other _____

Mother's Name (Last, First Middle): _____ Date of Birth: _____
 Father's Name (Last, First Middle): _____ Date of Birth: _____

Address and Phone Number, if different from above:

Address: _____ City: _____ UTAH Zip: _____
 Home Phone: _____ Work Phone: _____
 Cell Phone: _____

Friend or Relative who can reach family:

Name (Last, First Middle): _____
 Address: _____ City: _____ UTAH Zip: _____
 Home Phone: _____ Work Phone: _____
 Cell Phone: _____

Referred by:

Referred by: _____ Agency: _____
 Address: _____ City: _____ UTAH Zip: _____

Problem, Condition, or Reason for Application:

Services Requested:

 Name of Patient or Legal Representative (Please print) Date

Signature of Patient or Legal Representative

- Parent of minor child
- Medical Power of Attorney
- Self (18 or older)
- Legal Representative
- Other, explain and attach documentation