UTAH DEPARTMENT OF HEALTH
Children with Special Health Care Needs

Application for Services

Reset Form

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 - Explain _____
○ 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 ○ Self (18 or older)
○ Medical Power of Attorney ○ Legal Representative
○ Other, explain and attach documentation

_____