MADISON COUNTY INDIVIDUAL & FAMILY SUPPORT SERVICE APPLICATION

Name of Individual with Disability ______________________ Date ____________

Mailing Address ______________________ Residence Address ______________________

City ______________ County __________ Zip ________ Phone ______________

SSN# ____________ Date of Birth ______________ Number in Family ____________

What is the disability? Intellectual disability

Name of person making referral ______________________ Relationship ______________

Agency ____

Address ______________________________ Phone ______________

Support Services Requested ____

Purpose of support service or assistance requested ________________________________

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Estimated cost of service requested $ ______________

Please provide copies of receipts, Thank You

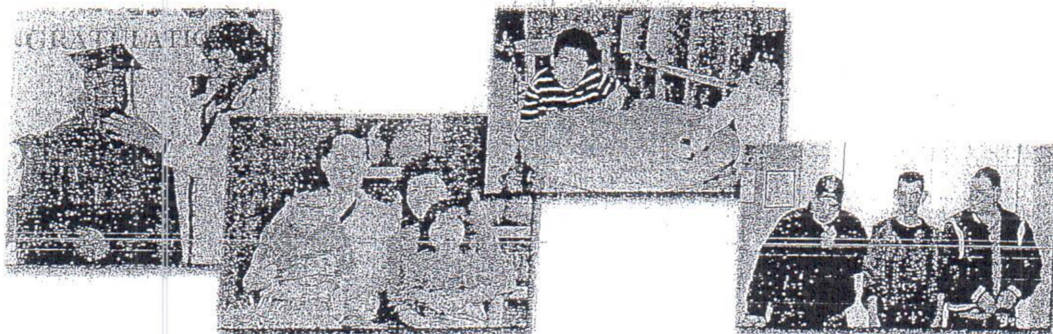
For service coordination purposes please check the following services the individual is receiving.

☑ Medicaid ☐ Private insurance ☑ DMH/MR ☐ AFDC ☐ Special Ed

☐ Medicare ☑ SSI ☐ Vocational Rehabilitation ☐ Crippled Children/CRS

Other ____

Signature ______________________



Make check payable to: ______________________

Mail check to: ______________________

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