

## CONSUMER APPLICATION

**Consumer Name:**

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**Date:**

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**Birthdate:**

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**Social Security Number:**

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**Address:**

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**City:**

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**State:**

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**Zip Code:**

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**Phone Number:**

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**County:**

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**Who Do You Live With:**

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**Relationship:**

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**Father:**

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**Mother:**

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**Address:**

---

**Address:**

---

**Home Phone:**

---

**Home Phone:**

---

**Work Phone:**

---

**Work Phone:**

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**Cell Phone:**

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**Cell Phone:**

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**Name of Guardian/Conservator:**

\_\_\_\_\_

**Address:**

\_\_\_\_\_

**State:**

\_\_\_\_\_

**Phone Number:**

\_\_\_\_\_

**Type/Nature of Guardianship:**

\_\_\_\_\_ **Full** \_\_\_\_\_ **Limited/Conservator**

**City:**

\_\_\_\_\_

**Zip Code:**

\_\_\_\_\_

**County:**

\_\_\_\_\_

**Other Interested Persons:**

**Name:**

**Relationship:**

**Address:**

**Phone Number:**

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**Education:**

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**Grade Completed:**

\_\_\_\_\_

**Address:**

\_\_\_\_\_

**Principal:**

\_\_\_\_\_

**Date Started:**

\_\_\_\_\_

**Date Left:**

\_\_\_\_\_

**Employment History:**

**Company:**

**Address:**

**Date Left:**

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**Hobbies and Interests:**

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**Diagnosis:**

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**Physical Limitations:**

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**General Health:**

\_\_\_\_\_ **Good**      \_\_\_\_\_ **Fair**      \_\_\_\_\_ **Poor**

**Emergency Information:**

**Person to Contact:**

**Phone Number:**

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**Alternate Contact:**

**Phone Number:**

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**Family Physician:**

**Phone Number:**

\_\_\_\_\_

\_\_\_\_\_

**Hospital/Clinic Preference:**

**Phone Number:**

\_\_\_\_\_

\_\_\_\_\_

**Insurance/Medical Coverage:**

**ID#:**

\_\_\_\_\_

\_\_\_\_\_

**Self Medicating**     **Yes**                       **No**

**Medications:**

**Dosage:**

**Times Taken:**

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\_\_\_\_\_

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**Other Specialists**

**Name:**

**Phone Number:**

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**Admission Data**

**Referring Agency:**

**Worker/Case Manager:**

\_\_\_\_\_

\_\_\_\_\_

**Funding Source:** \_\_\_\_\_

**Date Entered Program:**

**Date Terminated:**

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**Please state any additional information of which Abilities Unlimited Inc. should be aware of:**

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**Signature of Person Completing This Form:**

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**Signature of Consumer:**

**Signature of Program Coordinator:**

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**Signature of Parent/Guardian:**

**Date Signed:**

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