1230 Roosevelt Avenue, York, PA 17404
(717) 846-7433 or 1-800-632-9063

APPLICATION FOR MH/MR

□ Waiver □ Non-Waiver

Client Name: _____
Last First Middle Initial

Address: _____
Street Address Apt. No. City State Zip Code

Mailing Address (if different than above): _____

□ Adams County □ York County

Home Phone **(REQUIRED)**: _____ Township **(REQUIRED)**: _____

Emergency Contact Name: _____ Phone No. _____

Physician's Name: _____ Phone No. _____

____/__ /_____ _____/_____/_____ Email address: _____@
Soc. Sec. No. Birth date _____

Destination: □ **CIT** □ **HART** □ **Shadowfax**

If under 65, do you have a medical assistance card? ____ Yes ____ No, if yes card #_____

Do you use any of the following mobility aids? (Check all that apply)

__ Manual wheelchair __ Walker __ Powered scooter ___ Visually Impaired
__ Electric wheelchair __Cane __ Guide dog

Are there any effects of your disability of which we need to be aware?_____
_____

Do you require an escort? __ Yes __ No
(If yes, you must complete an escort form or have your doctor mail us a letter stating that you need one)

I hereby certify that the above information is true and correct, to the best of my knowledge, information and belief.

Supports Coordinator Signature _____ **Date:** _____