agency for persons with disabilities
State of Florida

AGENCY FOR PERSONS WITH DISABILITIES
Client Information Sheet

Date:		**Name:**					
		SSN:		**County**			
		Address:					
Primary Disability:							
Secondary Disability:		**Phone #:**	**Day:**		**Evening**:		
Referral Date:		**Email:**					
Referred By:		**TDD (Telephone Device for Deaf)**					
Area of Residence:		**DOB:**		**Age**:		**Male**:	**Female**:
		Legal Status:					
		Guardian Type/ Area:					
Insurance/ Resources: (Please complete)		**Directions to Home:**					
Health Insurance Company:							
Policy #:							
Medicare #:							
Medicaid #:							
Military Benefits:							
Income Amount: **SSI** **SSA:** **Other**							
Other Resources:)							
Background and Personal Information		**Place of Employment**					
Other Names/ Nick Names:		Employer:					
Primary Language In Home:		**Address:**					
Are Interpreter Services Needed?	☐ **Yes** ☐ **No**						
If yes, what kind or language?							
Available Transportation:	**None**		**Self**		**Bus**		**Phone #:** Ext.
Taxi		**Family**		**Walk**		**Volunteer**	
Other(Specify):							

Name:	
SSN:	

People to Contact		
Relationship	Name/Address	Phone #/Email
Guardian		
Mother		
Father		
Other Relatives		
Friends		

Programs/ Agencies Involved with Individual/ Family (include health care providers)			
Agency/Program:			
Contact Person:		Phone Number:	
Address:			
Agency/Program:			
Contact Person:		Phone Number:	
Address:			
Agency/Program:			
Contact Person:		Phone Number:	
Address:			
Agency/Program:			
Contact Person:		Phone Number:	
Address:			
Agency/Program:			
Contact Person:		Phone Number:	
Address:			

Additional Information:		Area	
		Contact Person:	
		Phone Number:	
Name/Title of Person Completing This Form:		Support Coordinator:	
Name:		Name:	
Title:		Phone Number:	