# Cerebral Palsy Association of Colorado Springs

## Client Application

**New_____ Renewal_____ (***Please check one)*

**Name of Client**: _____**Birth Date**:_____

**Parent(s)/Guardian(s)**: _____

**Address**: _____**City**_____ **Zip Code**: _____

**County**_____ **E-Mail** _____

**Home Phone**: _____**Work**:_____ **Cell**: _____*Best time to call*_____

***U.S. Citizen** or Legal Immigrant? Yes_____ No_____ ***Family size:** _____

***Client diagnosis: Cerebral Palsy_____ Neuro-Motor_____ unknown_____ Other_____**
**(*this information is used for statistics within our organization only/no names used)**

**Have you applied for SSI or Medicaid?** Yes _____No _____

Status: Approved_____ Denied _____Waiting List _____ No Response to Date_____

Is client enrolled in therapy at school/ any other program? Yes_____ No_____

Please list all providers location, type and frequency:

_____

_____

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**Is client covered under any health insurance, including Medicaid and Medicaid waiver?**

Yes_____ No_____

Primary Coverage _____Secondary Coverage_____

**Have you requested assistance from any other agency?** Yes _____ No _____

If yes, list **ALL** agencies, their response(s) and contact person. (example: The Resource Exchange,

Shriner's, Friends of Man, etc.)_____

_____

**Place of Employment** _____

**Military** Yes _____ No _____

Your Application cannot be processed if incomplete/missing items-Please double check

____Application Complete?

____Other Agency Denials? (if applicable)

____Funding Request estimates? (if applicable)

____Funding request pictures/contacts/prescriptions, acceptance letters? (if applicable)

____Progress notes/New or Ongoing Goals if applying for continuing funds for a current Therapy/Rec. Services? (if applicable)

____Have you signed your application?

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**Individual or Family Membership in the Cerebral Palsy Association of Colorado Springs is strongly encouraged.**
**(Please let us know if this presents a hardship)**

**Family Membership $10/per year _____**

**Individual Membership $5/per year _____**

This Membership entitles you/your family to- attend events, request funding, the use of loan items and any other services offered by CPACS.

I, _____authorize CPACS to use (anonymously) pictures of myself/family for our website, publications or posting in our office.

Sign _____Dae _____

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***Office Use Only***

Date Received _____ Amount Received _____Form _____

Entered:
GIK _____Annual Membership _____Email _____DataBase _____

By _____Date _____

Information Updates _____ _____ _____ _____