Help Them Grow

Help Them Grow
NOW/COMP Intake

Today's Date:	Is this a New App?	How did you hear about us?
If a minor, does child have any money in their name? If so, how much, and what kind of Account?		

Applicant	
Name:	Date of Birth:
Street Address:	Medicaid Number if Applicable:
City, State, Zip:	Social Security Number:
County of Residence:	Country of Citizenship:
Medicare Number	Medicaid Number

Contact Information	
Person Completing this Form:	Relationship to Applicant
Mobile #:	Email:
Street Address:	City, State, Zip:
Are you the primary contact for this Applicant?	

Circle one. Is child a			
Minor?	Competent?	Legally Incompetent?	Have a Guardian?

Guardianship	
Guardian Name:	Relationship to Applicant:
Street Address:	City, State, Zip:
Phone:	Email:

Please list all physicians Applicant sees. If you do not have enough room, list additional information at the bottom of this form.	
Physician Name:	Phone:
Street Address:	City, State, Zip:
Physician Name:	Phone:
Street Address:	City, State, Zip:
Physician Name:	Phone:
Street Address:	City, State, Zip:

School and BCW (If applicant attends school)					
Name of Public School	Name of Private School	Hrs/Day	Days/Week	IEP	IFSP

Hospitalizations/Surgeries – Please Note Overnight Stays or ER Visits.							
Date Hospitalized	Date Released	Procedure	Outcome	Date Hospitalized	Date Released	Procedure	Outcome

Medication							
Medication	Strength	Route	Frequency	Medication	Strength	Route	Frequency

What are your disabilities?

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Describe the type of service you believe you need:

Attach:

- Psychological Evaluation
- Copy of Birth Certificate
- Copy of SS Card
- Copy of Medicaid/Medicare Card
- Copy of SS Benefit Information
- Copy of Guardianship Paperwork
- IEP
- Medical Records