

UTAH DEPARTMENT OF HEALTH
Community and Family Health Services Division
Children with Special Health Care Needs
ABLE PROGRAM
PO Box 144640, Salt Lake City, UT 84114-4640
Phone: 801-584-8552 FAX: 801-584-8562
Toll Free: 1-800-829-8200 (Voice & TDD) 1-800-826-9662

APPLICATION FOR SERVICES

Person to Receive Services:

Name (Last, First Middle): _____ Date of Birth: _____

Address: _____ City: _____ UTAH Zip: _____

County: _____ Home Phone: _____ Work Phone: _____

Sex: **M** **F** Race: _____ Hispanic Pacific Islander

Social Security Number: _____ Language Spoken in the Home: _____

Parent Guardian Spouse Other

Mother's Name (Last, First Middle): _____

Father's Name (Last, First Middle): _____

Address and Phone Number, if different from above:

Address: _____ City: _____ UTAH Zip: _____

Home Phone: _____ Work Phone: _____

Friend or Relative who can reach family:

Name: _____

Address: _____ City: _____ UTAH Zip: _____

Home Phone: _____ Work Phone: _____

Referred by: _____ **Agency:** _____

Address: _____ City: _____ UTAH Zip: _____

Problem, Condition or Reason for Application: _____

Services Requested: _____

Release and Consent:

- 4 I understand that community and Family Health Services (CFHS) collects and shares information with others as necessary to facilitate the mutually agreed upon services and treatment.
- 4 I consent to services and treatment to be provided by CFHS to which is mutually agreed.

Signature: _____ Date: _____

The policy of CFHS is to provide reasonable accommodations to the known disabilities of patients and their families in compliance with the Americans with Disabilities Act.