



REGISTRATION FORM

Office Use Only: Entered in DB _____ Date Rec'd _____
 Month _____ Class: Type _____ Day _____
 Pmt: CC / Check # _____ DMH # _____

PLEASE RETURN ALL FORMS BY 12/15/2009

Rider Name _____ M F DOB _____ SSN# _____

Home Address _____ City _____ State _____ Zip _____ County _____

Email Address _____ Home Phone _____ Day Phone _____

Cell Phone _____ Emergency Contact & Phone _____

Mother's Name _____ Mother's Occupation _____ Employer _____

Mother's Work Phone _____

Father's Name _____ Father's Occupation _____ Employer _____

Father's Work Phone _____

Rider's Physician _____ Physician ID _____ Physician Phone _____

Rider's Therapist _____ Therapist's Phone(s) _____

Current Residence (check one): Lives w/Family Foster Home Nursing Home Lives Independently
 Group Home Individualized Supported Living Specialized Facility

If Group Home please provide address and phone: _____

CLIENT PHYSICAL INFORMATION:

Height _____ Weight _____ Verbal Non-Verbal

Ambulatory Non-Ambulatory Wheelchair Walker Cane

Appliances, if any: (ex: AFO's, glasses) _____

Seizures? _____ Allergies: _____

Medications _____

Diagnosis _____

Goals _____

Are you a "Dept. of Mental Health" client? Yes No
If so, please supply DMH # here: _____

PREVIOUS TH RIDER?
 YES
 NO

OPTIONAL INFORMATION: *The following information is needed at times for grant applications:* _____ # living in your/your child's household
Ethnicity (check all that apply): African American Asian Hispanic/Latino Caucasian Native American Multiethnic
Income Level Per Year (circle one): 11,000 – 15,000 15,001 – 19,000 19,001 – 25,000 25,001 – 30,000 30,001 – 45,000 45,001 – 60,000
 60,001 – 75,000 75,001 – 90,000 Over 90,001