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:	