Sammie Gail Sanders Children's Learning Center
Initial Contact/Application for Service

Date: _____________

Parent/Guardian: _______________________________ **Relationship to Child (ren): ____________________**

Child's Name: ___________________________ **DOB: _______________** **Gender: ____________**

Child's Name: ___________________________ **DOB: _______________** **Gender: ____________**

Child's Name: ___________________________ **DOB: _______________** **Gender: ____________**

Address: ____
(Street Address) *(City)* *(State)* *(Zip code)* *(County)*

Social Security Number:____________________ **Medicaid Number: _______________________**

Primary Phone Number: ___________________ **Alternate Number: _______________________**

Email Address:____@_________________________________. com

Type of services needed: DDTCS: _______________ Childcare: _____________ First Connections: ____________

Do you have any specific concerns about your child's development?

- ☐ **Speech**
- ☐ **Walking**
- ☐ **Social skills**
- ☐ **Feeding**
- ☐ **Behavior**
- ☐ **Other _______________**

Has your child been diagnosed with a disability? If yes please explain:____
____

How did you hear about us? ☐ **Internet** ☐ **Doctor's office** ☐ **Family/friend** ☐ **Walk-in** ☐ **AEDD/SGSCLC Staff**
____

For Office Use: (Check that apply)

- ☐ **Information Provided**
- ☐ **Screening Scheduled**
- ☐ **Medicaid Assistance Required**
- ☐ **Referral Form/EPSDT Provided**
- ☐ **Referral Form/EPSDT Faxed**
- ☐ **Voucher Obtained**
- ☐ **Referred to outside provider**
- ☐ **Parent declined services**
- ☐ **Did not Qualify/Referred**
- ☐ **Lost contact with family**

____
Staff Signature

____
Title

Revised 4/2017