We give help, **you give hope**

Individual Client Registration

Incomplete registrations will not be considered

____
Date

____
Name of Applicant (Please print or type)

____
Street **(Address of Applicant)** City State Zip

Gender: Male _____ Female _____ _______ Age _____________ Date of Birth _____________ Ethnicity (optional)

_______________ Home Phone _______________ Cell Phone _______________ E-mail

Degree of mental retardation (mild, moderate or severe) ____________________________

Does Applicant: Live with family ______ Foster Care ______ ILS ______ SLS ______
Residential Care Facility ______ Other ______

____
Name of Guardian

____
Street **(Address of Family/Guardian)** City State Zip

_______________ Home Phone _______________ Cell Phone _______________ E-mail

Please attach a copy of a Regional Center assessment for applicant, along with Case Manager's name. If not a Regional Center client, please send a *Doctor's Diagnosis* with registration form.

Revised in January 2011

Community Assistance for the Retarded and Handicapped, Inc.
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