Applicant Approval and Information Form

(In order to protect a person's privacy, complete the following information only after the **Authorization for Release of Medical Information** section of the Caring Resources for Living All Purpose Release Form has been signed.

Has the Release of Personal Information Form, **STEP TWO**, been signed and returned to Caring Resources for Living?
☐ YES ☐ NO

Client Information

Client Name: _____ _____
(first) (last)

Address_____
(street #) (city) (state) (zip code)

Date of Birth _____ Present Age: _____ Sex: ☐ M ☐ F

Primary Diagnosis: _____Month/Year of Diagnosis: _____

Physician's Name:_____

Parent/Guardian/Primary Caregiver Information

Parent/Guardian/Primary Caregiver Name: _____

Relationship to Client: _____

Home Phone # (_____)_____ Work or Cell #: (_____)_____

Parent/Guardian e-mail address: _____

Please check the best way for CRL to contact the Parent/Guardian/Primary Caregiver (required): ☐Phone ☐E-Mail

Referring Professional Information

Referral Source (name): _____

☐ Physician ☐ Registered Nurse ☐ Medical Social Worker ☐ Home Health Agency ☐ Other: _____

Please write in the best way for CRL to contact the referring professional (required): _____
(phone number or e-mail)