CONSUMER APPLICATION FOR CDPAP SERVICES

To be completed by the Consumer / Parent / Guardian / Designated Representative.

Consumer Information:			
Last Name:	First Name:	Middle Name:	Application Date:
Address:	City:	State:	Zip:
Social Security No:	Date of Birth:	Age:	Gender:
Email:	Home No:	Cell No:	
Parent / Guardian / Designated Representative Information (if applicable):			
Last Name:	First Name:	Relationship to Consumer:	
Email:	Home No:	Cell No:	
Medicaid Insurance Information:			
Medicaid Managed Care Plan:	Managed Insurance Member ID:	Medicaid Member ID:	
Policy Holder Last Name:	Policy Holder First Name:	Policy Holder Date of Birth:	
Secondary Insurance Information (if applicable):			
Secondary Insurance Plan:	Secondary Insurance Member ID:		
Policy Holder Last Name:	Policy Holder First Name:	Policy Holder Date of Birth:	
Physician and Diagnosis Information:			
Physician Name:	Physician Address:		
Physician Phone Number:	Physician Fax Number:	Physician Email Address:	
Diagnosis Code:	Secondary Diagnosis:	Doctor Assigning Diagnosis:	
Other Information:			
How did you learn about our services? (Circle One) Online research / Email / Sister Agency / Other:			
Name of Personal Assistant? What is the Consumer's relationship with this person?			

Consumer/ Parent / Guardian / Designated Representative: ____

Consumer/ Parent / Guardian / Designated Representative Signature: ______________________________________

EMAIL this completed form to intake@nycdpap.com or FAX to 800.765.7486.

To obtain this form in other languages please contact our office at 800-765-7485.