STATE OF MISSOURI
DEPARTMENT OF MENTAL HEALTH
DIVISION OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES

INITIAL CONTACT

PROSPECTIVE CLIENT			DATE
ADDRESS			PHONE
DATE OF BIRTH	SOCIAL SECURITY NUMBER		MEDICAID NUMBER
LEGALLY RESPONSIBLE PARTY		ADDRESS	
PHONE (HOME)	PHONE (WORK)	COUNTY	
SOURCE OF REFERRAL AND RELATIONSHIP		INTAKE WORKER (N) (I)	

Has individual for whom services are requested been served previously by this or any other regional center or other state agency? ☐ No ☐ Yes Specify ________________

REASON FOR REFERRAL/SERVICES REQUESTED

REASONS TO SUSPECT ELIGIBILITY:

- ☐ Apparent Substantial Functional Limitation
- ☐ Subaverage Intellectual Functioning
- ☐ Eligible for First Steps Program
- ☐ Special Education
- ☐ Presence of At-risk Factor
- ☐ Age of Manifestation
- ☐ Reported Medical Condition
- ☐ Other ________________

Check If First Steps application ☐

REMARKS OR DIRECTIONS TO HOME

Has inquirer been notified that there may be charges for services and of the requirement to fill out a Standard Means Test? ☐ Yes ☐ No

☐ Case Transferred to ________________

☐ Application Initiated

REFERRED TO:	FOLLOW-UP: