

New Jersey Department of Human Services
Division of Developmental Disabilities
Request for Service

Letters sent

Applicant: _____ Serial: _____
First Middle Last

Also Known as: _____ Social Security #: _____/_____/_____

Date of Birth: ____/____/____ Sex: _____ Marital Status _____

Veteran: (Y/N) _____ Primary Language: _____ NJ Resident: (Y/N) _____

Present Living Arrangement

Since (give date) ____/____/_____

Name: _____ lives on own
_____ lives with relative (relationship)

Address: _____ health care facility

P.O. Box/Apt. #: _____ out-of-home placement paid by:

City/State/Zip: _____ other (specify)

Phone No.: ____/____/____ County: _____

Employment/School/Day Program

Start Date: ____/____/_____

Name: _____ early intervention
_____ school program (home district)

Address: _____ competitive employment

P.O. Box/Apt. #: _____ sheltered workshop

City/State/Zip: _____ other: _____

Phone No.: ____/____/____ Contact person: _____

Referral Source Relationship to Applicant: _____

Name: _____

Home Phone: ____/____/____ Work Phone: ____/____/____

Contact Person(s) Relationship to Applicant: _____ Letters sent

Name: _____ Is this person a NJ court appointed guardian?

Address: _____ yes _____ no

P.O. Box/Apt. #: _____ Home Phone: ____/____/____

City/State/Zip: _____ Work Phone: ____/____/____

Developmental Disabilities

_____ Mental Retardation _____ Cerebral Palsy _____ Spina Bifida _____ Autism
_____ Neurological Impairment _____ Epilepsy _____ Head Injury _____ Other

Age of onset of disability: _____

