GOLDEN GATE REGIONAL CENTER

ONGOING INTAKE CONTACT FORM

Please note - This is NOT an intake or an application form for the assessment process. We will be calling applicants to complete the intake over the phone.

Applicant's Information *(Please Print)*

Name of person who wants to apply for GGRC services: (LAST NAME, FIRST NAME)

Date of Birth & Age:	**Sex :**

Address: - if homeless, please indicate shelter if applicable

Contact Info: - name + relationship + phone # + email

Who is the person living with: - name + relationship

Language (s):	**City/Country of Birth?**

Nature of Inquiry

Please circle the applicable concerns/diagnoses:

A) *(Only for children below 3 years old)* Developmental Delays – speech, motor, etc.;

B) Mental Retardation; **C)** Cerebral Palsy

D) Autistic Disorder **E)** Epilepsy

F) Condition that is similar to, or requires treatment similar to mental retardation

If you have a concern/diagnosis that is not listed above, please indicate it below:

Who referred you to GGRC? - name and/ or agency

Have you ever applied for GGRC services, or, received services from another regional center before?

Do you know if someone else has applied for GGRC services for you before? - If yes, who is he/she?

Release of Information

Are You the applicant? i.e. is this form filled out by the person needing GGRC services?

- If not, please state your name, relationship with applicant and contact # or email:

Please Initial next to those you would like to give permission to release your information to GGRC.

A) GGRC can contact the person who completed this form; INITIAL: _____

B) GGRC can to contact the following person (print name and number): INITIAL: _____

Signature and Date :	