ST. LOUIS OFFICE FOR
Developmental
Disability Resources

Division of Developmental Disabilities: Targeted Case Management Application Request

Date: _____

To whom it may concern,

I am interested in applying for Targeted Case Management services for individuals with a diagnosis of a developmental disability. I am requesting the assistance of the St. Louis Office for Developmental Disability Resources to submit this request for an application on my behalf. I understand that this form only serves as a request for an application to apply for services and does not guarantee my eligibility for services. I am granting the State of Missouri, Department of Mental Health- Division of Developmental Disabilities, permission to review the information given below and contact me to verify my request for an application prior to sending it.

First Name: _____ Middle Name/Initial: _____ Last Name: _____

If applicable, please list any other names _____

Date of Birth: ___/___/___/ Social Security Number: _____-_____-____

Email:_____ Do You have Active Medicaid? _____

Current Address: _____

Current Phone Number: (___)_____-_____

If known, what is your current developmental disability diagnosis? _____

Did you ever receive special education services? _____ If yes, what school district? _____

Do you have any immediate needs/concerns? _____

Have you had case management services with the Department of Mental Health previously? _____

_____
Consumer/Guardian Signature