ST. LOUIS OFFICE FOR
Developmental
Disability Resources

Choice of Provider for Targeted Case Management

St. Louis Regional Office/St. Louis Office for Developmental Disability Resources

Date _____

✓ I am interested in receiving Targeted Case Management (Service Coordination) from the St Louis Office for DD Resource. I understand that if I choose the St. Louis Office for DD Resources that they will be my provider for Targeted Case Management services. ***(Send Paperwork to DD Resources)***

Must be 2.5 years old or older
Must have active Medicaid

_____ I am interested in receiving Targeted Case Management (Service Coordination) services with the St. Louis Regional Office. ***(Send/Keep Paperwork to SLRO)***

Consumer Name _____ DMH # _____

DOB _____ SSN _____

Street Address _____ Apt. # _____

City _____ State MO ZIP _____ Phone # _____

Support Coordinator _____ Phone # _____

Applicant's Disability _____

Specific Need(s) _____

_____ _____
Signature of Applicant, Parent, or Guardian Date signed

_____
Printed Name of Person Signing