ST. LOUIS OFFICE FOR
Developmental
Disability Resources

Established Relationship Form for Targeted Case Management

St. Louis Office for Developmental Disability Resources

Date _____

✓ I am interested in receiving Targeted Case Management services. I attest that I have an established relationship with the St. Louis Office for DD Resources and I request that they be my provider for Targeted Case Management services. ***(Send Paperwork to DD Resources)***

Must have a developmental disability diagnosed prior to age 22
Must have active Medicaid

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