Date of initial contact:_________
Follow-up date:_________
Follow-up date:________
Intake Person:_________

Application for Services (C1.2)

Please fill out application in its entirety and return to:

FSU ECAP Applications
4750 Collegiate Drive
Panama City, FL 32405
or by email to — fsuecap@fsu.edu

Parent(s) or Guardians (s) Name(s): ____

Child's Name:____ Age:____ DOB:____________

Diagnosis(es): ____ Date Diagnosed:__________

School: ____ Grade: ____________

Home Address: ____
____
____

How many hours of therapies are you requesting?________

Phone: (h) ________________________________ (w) ________________________________

(c) ________________________________ Email:___________________________________

Funding Source (circle all that apply): FL Medicaid Out of Pocket/ Private Pay

Insurance (Please specify company/state: _______________) None (scholarship needed)

Policy Number:________________ **Funding Source Contact Number**:__________________

Availability: List all days and times your child is available for therapy (sessions are usually 2-3 hours):

____
____
____
____

Needs: Comments on the child's communication ability, concerns, skills needed, etc.: _______________

____
____
____
____
____
____

Property of ECAP. Use by others is prohibited

Application for Services (C1.2) ***continued***

Previous Providers: ( ) ABA ( ) Speech ( ) OT ( ) Other: ___________________

Previous Provider Contact Information:

By signing below, I give permission to FSU ECAP to contact and request records from previous service providers.

______________________	______________________	______________________
Name	Signature	Date

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