Date of initial contact:_____
Follow-up date:_____
Follow-up date:_____
Intake Person:_____

Application for Services

Please fill out application in its entirety and return to:

FSU ECAP Applications
4750 Collegiate Drive
Panama City, FL 32405
or by email to — hsaas@pc.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: _____

_____

_____

_____

_____

_____

_____