SUCCEEDING DESPITE INC.

CLIENT APPLICATION FORM

PERSONAL INFORMATION

Full Name :

Date of Birth : ____/____/____ **Gender** : ☐ Male ☐ Female

Address : ____

Phone Number : ____ **E-Mail** : ____

ID Number : ____ **Social Security#** : ____

Status : ☐ Single ☐ Married ☐ Divorce ☐ Others

Type of Service Requested? : ____ **Are You A Retiree ?** ☐ Yes ☐ No

Do you have a disability or a health condition that requires assistance during a trip? ☐ Yes ☐ No

If yes, please describe: ____

Is your disability/health condition permanent or temporary? ☐ Yes ☐ No

EMERGENCY CONTACT DETAILS

Contact Name : ____ **Home Number** : ____

Relationship : ____ **Mobile Number** : ____

MOBILITY AIDS

Check any and all mobility equipment that you expect to use while traveling:

◯ Cane □ Braces □ Crutches □ Walker □ White Cane □ Manual Wheelchair

◯ Motorized Wheelchair □ Service Animal □ Scooter □Respirator/Oxygen

◯ Other:

3. Do you require the assistance of another person during travel or at your destination?

◯ Always □ Sometimes □ Never

More Information :

P,O. Box 4681 Capitol Heights MD 20743

+301-636-7161 (Office)

www.succeedingdespite.org

THANK YOU,
EXTENDED FAMILY PROGRAM

____
Print Name

____
Client Signature

OFFICE USE ONLY

Date : _____

Membership/Pay Rate : _____

Referral Source : _____

Payment Type : _____

Staff Name : _____

Staff Signature : _____

Notes : _____