

ILRC REQUEST OF SERVICES

Person Requesting Service(s) If Child, (Parent/Guardian) Name Date of Birth

Address (Street City State Zip County)

Contact Phone # When **NOT** to call? E-mail address

Disability(s)

SERVICES REQUESTING (Select one or more of our services or give description)

- | | |
|---|---|
| <input type="checkbox"/> Independent Living Skills Training | <input type="checkbox"/> Peer Support |
| <input type="checkbox"/> Assistive Devices/Equipment | <input type="checkbox"/> Housing & Shelter Services |
| <input type="checkbox"/> Advocacy | <input type="checkbox"/> Home Modifications |
| <input type="checkbox"/> Transportation | <input type="checkbox"/> Support Groups |
| <input type="checkbox"/> Equipment Loan & Donation | <input type="checkbox"/> TAP for Telephone/Internet |
| <input type="checkbox"/> Healthy Children and Youth | <input type="checkbox"/> Consumer Directed Services |
| <input type="checkbox"/> Information & Referral | |
| <input type="checkbox"/> Other _____ | |
-

Current Living Arrangements

- | | |
|--|--|
| <input type="checkbox"/> Independent | <input type="checkbox"/> Dependent w/Family or Friends |
| <input type="checkbox"/> Assisted Living | <input type="checkbox"/> Institution |
| <input type="checkbox"/> Other _____ | |

Comments/Notes: _____

Signature: _____ Date: _____