1998 CONEY ISLAND AVENUE BROOKLYN, NEW YORK:
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1.833.CARE365 // P: 718.627.7050
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Please feel free to reach us at
718.627.7050 or fax to **718.627.4800**

HOMECARE: *Always Available*

CONSUMER APPLICATION FOR CDPAP SERICES

To be completed by the Consumer/ Parent / Guardian / Designated Representative

CONSUMER INFORMATION			
Last Name:	First Name:	Middle Name:	Application Date:
Address:	City:	State:	Zip:
Social Security Number:	Date of Birth:	Age:	Gender:
Email:	Home Number:	Cell Number:	
PARENT / GUARDIAN / DESIGNATED REPRESENTATIVE INFORMATION (IF APPLICABLE);			
Last Name:	First Name:	Relationship to Consumer:	
Email:	Home Number:	Cell Number:	
MEDICAID INSURANCE INFORMATION			
Medicaid Managed Care Plan:	Managed Insurance Member ID:	Medicaid Member ID:	
Policy Holder Last Name:	Policy Holder First Name:	Policy Holder Date of Birth:	
SECONDARY INSURANCE INFORMATION (IF APPLICABLE);			
Secondary Insurance Plan:	Secondary Insurance Member ID		
Policy Holder Last Name:	Policy Holder First Name:	Policy Holder Date of Birth:	
PHYSICIAN AND DIAGNOSIS INFORMATION			
Physician Name:	Physician Address:		
Physician Phone Number:	Physician Fax Number:	Physician Email Address:	
Diagnosis Code:	Secondary Diagnosis:	Doctor Assigning Diagnosis:	
OTHER INFORMATION			
How did you hear about our services? (Check One)	☐ Online research ☐ Email	☐ Sister Agency	☐ Other
Name of Personal Assistant? What is the Consumer's relationship with this person?			

Consumer / Parent / Guardian / Designated Representative: ____

Consumer / Parent / Guardian / Designated Representative Signature: ____