

# Intake Application



**The Asperger Spirit**

Date: \_\_\_\_\_

Name of Applicant \_\_\_\_\_

Current Address \_\_\_\_\_

\_\_\_\_\_

Telephone No. \_\_\_\_\_ Email Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Referred By: \_\_\_\_\_

Reason for Referral: \_\_\_\_\_

\_\_\_\_\_

Parent/Guardian/Representative

(if applicable): \_\_\_\_\_

Telephone No.: \_\_\_\_\_ Email Address: \_\_\_\_\_

Reason for Funding

Request: \_\_\_\_\_

Total Amount Being Requested for Services \$ \_\_\_\_\_

Cost Per Unit of Service (Ie. cost per hr., 30min., etc): \_\_\_\_\_

Date by which Funds are needed \_\_\_\_\_

Name and Address of Intended Service Provider: \_\_\_\_\_

\_\_\_\_\_

Contact at Intended Service Provider \_\_\_\_\_

Telephone Number of Intended Service Provider: \_\_\_\_\_

\_\_\_\_\_  
Signature (Applicant)

\_\_\_\_\_  
Signature of Parent/Guardian/Representative  
(If applicable)

***Please attach official document stating diagnosis from an educational, medical or psychological professional.***

*To Be Completed Internally :*

\_\_\_\_\_

*Intake Staff Name (Print)*

*Intake Staff Name (Signature)*

*Date Application Received* \_\_\_\_\_