



# REGISTRATION FORM

## Medically Fragile Waiver

*For official use only*

*date stamp*

Please indicate the Medically Fragile condition and the Developmental Disability:

APPLICANT INFORMATION				SEX	Language Preference:
Name – Last	First	Middle Initial			Date of Birth
			<input type="checkbox"/> M		
			<input type="checkbox"/> F		
Street Address	City	State	Zip Code	Social Security Number	
Mailing Address (if different from street address)	City	State	Zip Code	Primary Telephone Number	
County of Residence	County in which services are requested (if different from residence)			E-mail Address	
First time applying? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know			Currently receiving Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, which MCO? _____ (BCBS, Presbyterian, or Western Sky)		

Name and relationship of person submitting registration form:

1. LEGAL REPRESENTATIVE INFORMATION*	<input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Power of Attorney <input type="checkbox"/> Agency
--------------------------------------	--

**\*Anyone other than the parent(s) of a minor child MUST include copies of documents that provide evidence of legal authority to act on behalf of the applicant.**

Name – Last	First	Agency Name (if corporate guardian)			
Street Address	City	State	Zip Code	Primary Telephone Number	
Mailing Address (if different from street address)	City	State	Zip Code	E-mail Address	

2. <input type="checkbox"/> AUTHORIZED REPRESENTATIVE OR <input type="checkbox"/> ALTERNATIVE/EMERGENCY CONTACT*	*Please ensure that an Authorization for Release of Information is provided for this person.
---	--

Name – Last	First	Relationship to applicant:			
Street Address	City	State	Zip Code	Primary Telephone Number	
Mailing Address (if different from street address)	City	State	Zip Code	E-mail Address	

*Si necesita ayuda o información en español, por favor llámenos al número 1-800-283-8415; oficina 1-505-328-6081; fax 505-841-2987.  
 If you are a person with a disability and you require this information in an alternative format or require special accommodation to participate in registration or services,  
 Please call 1-800-283-8415; office 1-505-328-6081; fax 505-841-2987*

*For official use only*

Registration Date:	Staff completing registration:	Initials & Date:	Staff entering registration in CR:	Initials & Date:	Region:
					<input type="checkbox"/> NWRO <input type="checkbox"/> METRO <input type="checkbox"/> NERO
					<input type="checkbox"/> SERO <input type="checkbox"/> SWRO