Support Services

For the Developmentally Disabled

2607 Bridgeport Way W Suite 2-J
University Place, WA 98466
253-383-2643 | Fax 253-572-8646 | www.supportservicesdd.org

Intake Form

Name_____Date_____M___F___

Address:_____City:_____Zip:_____

Home Phone:_____Message Phone:_____

Birth Date:_____Birthplace:_____

Social Security #: __ __ __ - __ __ - __ __ __ __ Claim number:_____

Source of Income:_____Amount:_____

Food Stamps:_____ Section Housing:_____

Father's Name:_____

Mother's Maiden Name:_____

Family:_____

_____

Living Arrangements:_____

DDD Case Manager:_____

Doctor:_____

Dentist:_____

Former Payee:_____

Immediate Needs:_____

Do you owe money for anything other than rent and utilities?_____

_____

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Release of Information

I,_____, give Support Services permission to discuss with and release information to the following agencies to assist in providing services for representative payee, housing, food, medical, transportation and/or:

_____

_____

_____

_____

_____

_____

_____

_____

Signature

Signature of Witness