



Children's Special Needs Network
 204 N. East St., Ste. F
 Belton, Texas 76513
 Fax (254) 933-7313
 (254) 933-7597 or (800) 600-3940
 www.special-children.org

Client Information Form

Name Relationship to child Annual Income Occupation

Parent/Guardian: _____

Parent/Guardian: _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

County: _____

(CSNN serves Bastrop, Bell, Blanco, Bosque, Brazos, Burleson, Burnet, Caldwell, Coryell, Falls, Fayette, Freestone, Grimes, Hamilton, Hays, Hill, Lampasas, Lee, Leon, Limestone, Llano, Madison, McLennan, Milam, Mills, Robertson, San Saba, Travis, Washington and Williamson Counties)

Telephone #: Home: _____ **Cell:** _____ **Work:** _____

Email address: _____ **Primary Language:** _____

*Please check if you **do not** want to be added to the CSNN email list.* _____

Referred By: _____

Are you military? Yes No

If so, are you enrolled with the Exceptional Family Member Program (EFMP)? Yes No

Please list any children with special needs in the home:

Name	Date of Birth	M/F	Race	Diagnosis

Please list any other children, adults or dependents living in the home:

Name	Age	Relationship to Child	Annual Income
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Does your child have a G-button, tracheotomy or have a condition that would require trained medical staff to take care of him or her? Yes No

Is child receiving help from any of the following?

Social Security Income: YES NO CSHCN: YES NO
Medicaid: YES NO CHIP: YES NO

Any other resources: _____

Primary Insurance: _____

Second Insurance: _____

Please provide a copy of any insurance cards, front and back.

Place a check in the blank next to each of the services below that could be helpful for your family:

- | | |
|--|---|
| <input type="checkbox"/> Community Resources | <input type="checkbox"/> Medical Equip & Supplies |
| <input type="checkbox"/> Dental | <input type="checkbox"/> Personal Care Services |
| <input type="checkbox"/> Diapers | <input type="checkbox"/> Respite Care |
| <input type="checkbox"/> Family Activities | <input type="checkbox"/> Special Education |
| <input type="checkbox"/> Legal Questions | <input type="checkbox"/> Summer Activities, Camps |
| <input type="checkbox"/> Medicaid Waiver Program | <input type="checkbox"/> Support Groups |
| <input type="checkbox"/> Medical | Other: _____ |

Please note that CSNN receives funding through grants from various organizations. Any information shared on this form will be available to those organizations.

Printed Name

Parent/Guardian Signature

Date