KRIS AGENCY & HOME CARE INC.
169-14 HILLSIDE AVE
JAMAICA, NY 11432
TELEPHONE: 718-262-9009 FAX: 718-262-8213

CONSUMER APPLICATION FOR CDPAP SERVICES

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 #:	Date of Birth:	Age:	Gender:
Email:	Home #:	Cell #:	
Parent / Guardian / Designated Representative Information (if applicable):			
Last Name:	First Name:	Relationship to Consumer:	
Email:	Home #:	Cell #:	
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 #:	Physician Fax #:	Physician Email Address:	
Diagnosis Code:	Secondary Diagnosis:	Doctor Assigning Diagnosis:	
Medications:			

EMAIL this completed form to CDPAP@KrisAgency.com or FAX to718-262-8213

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

Consumer Information:			
Last Name:	First Name:	Middle Name:	Social Security #:

Other Information:
How did you learn about our services? (Circle One) Online research / Referral / Social Worker Other:
Name of Personal Assistant? We recommend Two (2) Personal Assistants for the continuation of care. Describe the Consumer's relationship with this person? 1. 2.

Consumer/ Parent / Guardian / Designated Representative: _____

Consumer/ Parent / Guardian / Designated Representative Signature: _____

For Administrative Use:

EMAIL this completed form to CDPAP@KrisAgency.com or FAX to718-262-8213.