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STATE OF MISSOURI

DEPARTMENT OF MENTAL HEALTH

ST. LOUIS COUNTY REGIONAL OFFICE
9900 Page Avenue, Suite 106
ST. LOUIS, MISSOURI 63132
(314) 587-4800
(314) 877-5606 FAX
www.dmh.mo.gov

APPLICATION REQUEST

Date: _____ **St. Louis County and St. Louis Tri County Offices**

I am interested in applying for services with the St. Louis Regional Office. Please send me an application packet.

First Name: _____ Middle: _____ Last: _____

Former Last Name (maiden name): _____ D.O.B: _____

Phone # _____ SS # _____ Medicaid # _____

Address: _____, City: _____, Zip Code: _____

Primary Language: _____ Is an interpreter needed? _____

Suspected Disability: _____

Specific Needs: _____

I received special ed. services in the following school district (name and address of last school district attended): _____

_____

Name and Address of Doctor or Clinic that can document a qualifying medical diagnosis that occurred before age 22: _____

_____

(cerebral palsy, seizure disorder, head injury, autism spectrum disorder, etc…)

Please send my application and appointment date to (name, address & phone number): _____

_____

I give permission for the person listed above to exchange information with the St. Louis Regional Office.

Printed name of applicant or legally responsible person: _____

Legally responsible person's relationship to applicant: _____

Signature of applicant or legally responsible person: _____

Please mail form to above address or fax to 314-877-1598