



Request for Screening for the Developmental Disabilities Waiver

Name of Person to be Screened: (Please Print) _____

Home Phone (with area code): _____ Cell phone: _____

Check one: Male Female Date of application: _____

Address: _____
Street Address

_____ City State Zip

Date of birth: _____ Age: _____ Social Security Number: _____

Name of parent/guardian: _____

Name of person completing this form: _____

Signature of person completing this form: _____

Please fill out this form completely and deliver to:
1241 North Main Street
Harrisonburg, VA 22802
Attention: Waiver Screening
Or
Fax to 540-432-0572