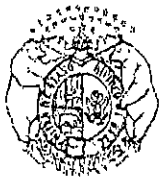
MATT BLUNT
GOVERNOR

KEITH SCHAFER, Ed.D.
DIRECTOR



BERNARD SIMONS, DIRECTOR
DIVISION OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES
(573) 751-4054
(573) 751-9207 FAX

ANITA CONTRERAS
EAST DISTRICT ADMINISTRATOR
314-340-6645
314-340-6589 FAX

CYNTHIA MUELLER
CENTER DIRECTOR – CITY
314-244-8867
314-244-8861 FAX

STATE OF MISSOURI
DEPARTMENT OF MENTAL HEALTH
ST. LOUIS REGIONAL CENTER
WAINWRIGHT STATE OFFICE BLDG.
111 N. 7th St. 6th FLOOR
ST. LOUIS, MISSOURI 63101
(314) 244-8800
FAX (314) 244-8804 – TTY (314) 244-8805
www.dmh.mo.gov

APPLICATION REQUEST

Please mail or fax to the St. Louis Regional Center when completed

Date:_____

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

First Name:_____Middle:_____Last:_____

Former Last Name (maiden name):_____

D.O.B.:_____SS #_____Medicaid #_____

Address:_____, Zip Code:_____

Phone #_____

Suspected Disability:_____

Specific Needs:_____

I received special ed. Services in...(circle all that apply)...St. Louis City, St. Louis County, The Archdiocese of St. Louis, Other_____

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

_____

(mental illness, cerebral palsy, seizure disorder, head injury, autism spectrum disorder, etc...)

Please send my application and appointment date to (name and address):_____

_____

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

Printed Name of Parent or Guardian_____Signature_____
If applicable

The Department of Mental Health does not deny employment or services because of race, sex, creed, marital status, religion, national origin, disability or age of applicants or employees.