



Customer Information Sheet

Date of initial meeting: _____ Date agreement requested or received _____

1) Managing Party/DHHS

Staff Name: _____

Address: _____ Phone: _____

_____ E-mail: _____

2) Consumer receiving services: _____

Address: _____ Phone: _____

_____ E-mail: _____

DOB: _____

Deaf Blind _____

Allocation amount: _____

Primary contact Billie Jo Webb

Date Initiating Services: _____

For office use only:

Check Service Model:

- FSE Agency with Choice FEA CSG Other

Note: If FEA, FEIN holder, relationship to person receiving services and FEIN # _____

Copies sent to _____ Director of Services _____ Billing specialist **Originals to** _____ Office Coordinator