Utah Department of Health & Human Services
Family Health

Application for Services

Reset Form

Person to Receive Services:

Name (Last, First Middle):_____Date of Birth: _____
Address:_____City:_____State:__ Zip: _____
Home Phone:_____ Cell Phone: _____
Work Phone: _____ E-mail: _____

Sex: ◯ Male ◯ Female

Ethnicity: ◯ Hispanic or Latino
◯ Non-Hispanic or Latino
◯ Declined

Race: ◯ White ◯ Black or African American ◯ American Indian or Alaskan Native
◯ Asian ◯ Native Hawaiian or Pacific Islander ◯ Other - Explain _____
◯ Declined

Languages Spoken in the Home: _____

Preferred Correspondence Method:

☐ E-Mail
☐ Standard Mail

◯ Parent ◯ Guardian ◯ Other_____

Mother's Name (Last, First Middle): _____ Date of Birth: _____
Father's Name (Last, First Middle): _____ Date of Birth: _____

Address and Phone Number, if different from above:

Address: _____City:_____UTAH Zip: _____
Home Phone:_____Work Phone: _____
Cell Phone: _____

Friend or Relative who can reach family:

Name (Last, First Middle): _____
Address:_____City:_____UTAH Zip: _____
Home Phone:_____ Work Phone: _____
Cell Phone: _____

Referred by:

Referred by:_____ Agency: _____
Address:_____City:_____ UTAH Zip: _____

Problem, Condition, or Reason for Application:

Services Requested:

_____ _____
Name of Patient or Legal Representative (Please print) Date

_____
Signature of Patient or Legal Representative

◯ Parent of minor child ◯ Self (18 or older)
◯ Medical Power of Attorney ◯ Legal Representative
◯ Other, explain and attach documentation

_____