Southeast Alaska RiteCare Program

Application for Treatment

(Please Type or Print)

Client's (Child's) Full Name: ____ Age:_____

Primary Caregiver's Name: ____

Address: ____Phone:_________________

City/State/ZIP: ____How Long?_________

Insurance Coverage?__________Insur. Company___________________________________

Eligible for: Medicaid: __________Veteran's Benefits:_____Other: ______________________

Alternate Caregiver's Name: ____

* Address: ____Phone:___________________

* City/State/ZIP: ____How Long?__________

* (If not the same as Primary Caregiver)

Eligible for: Medicaid:__________Veteran's Benefits: ______Other:______________________

Name, Ages & Gender of Other Children at Home: ___________________________________

____

(They Will be Invited To Our Annual Christmas Party)

Other Items of Importance For Processing This Application: ___________________________

____

____

I hereby certify the information on this form to be true and complete to the best of my knowledge.

Signature: ____ Date: _________________

Southeast Alaska RiteCare Program
P.O. Box 32558, Juneau, AK 99803
(907) 586-1185 Msg / FAX