



ADULT REGISTRATION FORM

Please complete all information on this form. If you need help, please speak to one of our Staff.

Last Name: _____ First Name: _____ Middle: _____

Preferred Name/Nickname: _____

Age: _____ Birth Date: ____/____/____ Sex: _____ SS#: _____ - _____ - _____

Referred by: _____ Referral Phone: _____

Address: _____ Apt #: _____ Phone: Home: _____

City/State/Zip: _____ Work: _____

Email: _____ Contact Preference: _____ Cell: _____

Primary Language: _____ Religious Preference: _____

Race: White Black Asian American Indian Alaskan Native Native Hawaiian Pacific Islander Multi-Racial

Ethnicity: Puerto Rican Mexican Cuban Other Hispanic Haitian Mexican American Spanish/Latino
(check one) None of the Above

Marital Status: Never Married Married Widowed Divorced Separated Domestic Partner Legally Separated

Employment Status: Active Military Full Time FT Self-Employ Part Time PT Self-Employ Unemployed Disabled
Retired Student Homemaker Leave of Absence Criminal Inmate Not Authorized to Work

Highest School Grade Completed: _____

Have you ever been known by another name or former alias: No Yes Name: _____

Do you have a case plan with the court system or Eckerd Community Alternatives: Yes No

Residential Status: Independent Living Alone Independent Living-with Relatives Independent Living-with Non-Relatives
Dependent Living-w/Relatives Dependent Living-w/Non-Relatives Homeless Group Home Jail
Assisted Living Facility Mental Health Institute Nursing Home Supported Housing Foster Care
DJJ Facility Crisis Residence Children Residential Treatment Limited MH Licensed ALF Other

Number in Household: _____ Have you ever received services here before? No Yes

Veteran: Yes No If so, when: _____

IDENTIFY DISABILITY FACTORS:

Developmental Disabilities: Yes No Physically Impaired: Yes No
Non- Ambulatory: Yes No Visually Impaired: Yes No
Deaf or Hard-of-Hearing: Yes No ADL Functioning: Yes No
English Language Severely Limited: Yes No (Inability to perform independently day-to-day living)

What auxiliary aids, services, or assistance do you need to help you communicate with us? _____

EMERGENCY CONTACT

Name: _____ Phone: Home: _____

Address: _____ Apt #: _____ Work: _____

City/State/Zip: _____ Relation: _____

Legal Guardian: Yes No

Client Name: _____ Client #: _____

MEDICAL BENEFITS

Medicaid #: _____

Medicare#: _____

Do you have any other insurance? (Other than Medicaid/Medicare) Yes No Name: _____

| | |
|---|--------------------------|
| I authorize the release of any medical information necessary to process this or a related claim to: | |
| _____ | Date: ____ / ____ / ____ |
| Insurance Company Name and Address | |
| I authorize payment of benefits to Directions for Living. | |
| _____ | Date: ____ / ____ / ____ |
| Signature | |

MEDICAL INFORMATION

| | |
|-----------------------------------|----------------|
| Primary Care Physician: _____ | Phone #: _____ |
| Other Treating Physician: _____ | Phone #: _____ |
| Pain Management Specialist: _____ | Phone #: _____ |
| Preferred Pharmacy: _____ | Phone #: _____ |
| Pharmacy Location: _____ | |

SERVICE AUTHORIZATION / CONSENT TO TREAT / CONSENT TO PARTICIPATE

My signature below certifies that:

- 1) I give permission to staff of Directions for Living to render mental health/substance abuse treatment and/or prevention services to the person named below.
- 2) I have received a copy of the Client Handbook which includes information regarding:

| | |
|--------------------------------------|------------------------|
| ▪ Organizational Mission | ▪ Hours of Operation |
| ▪ Emergency Procedures | ▪ Treatment Services |
| ▪ Client Rights and Responsibilities | ▪ Grievance Procedures |
| ▪ Infectious Disease Control | ▪ HIV/AIDS Education |
| ▪ Notice of Privacy Practices | ▪ Advance Directive |
- 3) I have received the HIV/AIDS education information and understand that I may ask for further information regarding testing and other services at any time.
- 4) I understand that I may be contacted about my services at Directions for Living during or after services for quality improvement purposes.
- 5) I understand that Directions may be required to submit statistical and demographic information such as my age, social security number and/or income to certain local, state and/or federal agencies in order to provide my services. I also understand that I may ask for more specific information regarding this at any time.
- 6) I am providing this consent to treatment and/or prevention services voluntarily and understand that I have the right to withdraw my consent at any time.

Print Client Name

Client Signature

____ / ____ / ____
Date

Guardian Signature (if applicable)

____ / ____ / ____
Date

Relation to Client

Witness

____ / ____ / ____
Date

Client Name: _____ Client #: _____

PERSONAL SAFETY PLAN / MENTAL HEALTH ADVANCE DIRECTIVE

Client Name: _____ Today's Date: _____

It is your right to make decisions about your own health care, and we want to follow your wishes especially if you are in crisis and not be able to tell us what you want. More importantly, your recovery is Directions' top priority and we want to help you prevent a crisis before it starts.

A Personal Safety Plan or Mental Health Advance Directive is one way you can let your treatment team know in advance how you would like us to respond if you should begin to feel worse.

We hope this form can give us a better sense of how to help you. Please take a minute to answer the following questions. If you have questions about filling this out, please ask any one on your treatment team. If you'd like, you can take this form home and bring it back at your next appointment.

1. Some of the warning signs that I am not feeling well are when I:
- Am Sad Am Angry / Irritable Have No Energy Isolate Drink / Use Drugs
 Sleep Too Little/Too Much Don't take care of myself physically Eat too much / too little
 Other: _____

2. Some things that may cause me to become very distressed are:
- Problems with friends or other people Financial Issues Getting sick Family Problems
 Problems where I live Problems with my job or school
 Other: _____

3. Some of the things that help me to cope when I am distressed are:
- Talking it Out Quiet Place Exercise Being with friends/family members
 Spiritual Beliefs Hobbies
 Other: _____

4. If I have to go to the hospital, I prefer to go to:
- Suncoast Hospital / Largo Medical Center PEMHS St. Anthony's
 Community Hospital Windmoor Morton Plant Hospital
 Other: _____

Please note: We cannot guarantee that you will be sent to your preferred hospital.

5. If I am in a crisis, what can Directions do to help you?
- Counseling Hospitalization Medication Contact family / friends
 Other: _____

Who is available to help you if you are in a crisis or begin to feel badly, such as a family member, friend, or case manager? (Please include name and phone number.)

May we contact them on your behalf?

Yes No
 Yes No
 Yes No

Client Signature

Date

Client Name: _____ Client #: _____

9600-018a

Rev. 08/01/2012

Finding Your ACE Score

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often or very often**...
Swear at you, insult you, put you down, or humiliate you?
or
Act in a way that made you afraid that you might be physically hurt?
Yes No If yes enter 1 _____
2. Did a parent or other adult in the household **often or very often**...
Push, grab, slap, or throw something at you?
or
Ever hit you so hard that you had marks or were injured?
Yes No If yes enter 1 _____
3. Did an adult or person at least 5 years older than you **ever**...
Touch or fondle you or have you touch their body in a sexual way?
or
Attempt or actually have oral, anal, or vaginal intercourse with you?
Yes No If yes enter 1 _____
4. Did you **often or very often** feel that ...
No one in your family loved you or thought you were important or special?
or
Your family didn't look out for each other, feel close to each other, or support each other?
Yes No If yes enter 1 _____
5. Did you **often or very often** feel that ...
You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
or
Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
Yes No If yes enter 1 _____
6. Were your parents **ever** separated or divorced?
Yes No If yes enter 1 _____
7. Was your mother or stepmother:
Often or very often pushed, grabbed, slapped, or had something thrown at her?
or
Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard?
or
Ever repeatedly hit at least a few minutes or threatened with a gun or knife?
Yes No If yes enter 1 _____
8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
Yes No If yes enter 1 _____
9. Was a household member depressed or mentally ill, or did a household member attempt suicide?
Yes No If yes enter 1 _____
10. Did a household member go to prison?
Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score.

Name _____

ENGLISH

Date _____

**Modified Simple Screening Instrument for Substance Abuse (MSSI-SA)
Self-Administered Form**

Directions: The questions that follow are about your use of alcohol and other drugs, including prescription and over-the-counter medication/drugs. Your answers will be kept private. Mark the response that best fits for you. Answer the questions in terms of your experiences in the past 6 months.

Filling out this form assists us in identifying your needs and providing you with services. Your answers on this form will not exclude you from services, care or treatment at this program.

During the last 6 months...

| | Yes | No |
|---|-------|-------|
| 1a. Have you used alcohol or other drugs? (Such as wine, beer, hard liquor, pot, coke, heroin or other opiates, uppers, downers, hallucinogens, or inhalants) | | |
| ----- | ----- | ----- |
| 1b. Have you used prescription or over-the-counter medication/drugs? (Such as sleeping pills, pain killers, sedatives, or anti-anxiety medication like Valium, Xanax, or Ativan) | | |
| 2. Have you felt that you use too much alcohol or other drugs? (Other drugs also include prescription or over-the-counter medication more than recommended.) | | |
| 3. Have you tried to cut down or quit drinking or using alcohol or other drugs? | | |
| 4. Have you gone to anyone for help because of your drinking or drug use? (Such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, counselors, or a treatment program.) | | |

| |
|---|
| 5. Have you had any health problems? Please check if you have: ___ Had blackouts or other periods of memory loss? ___ Injured your head after drinking or using drugs? ___ Had convulsions, delirium tremens (“DTs”)? ___ Had hepatitis or other liver problems? ___ Felt sick, shaky, or depressed when you stopped? ___ Felt “coke bugs” or a crawling feeling under the skin after you stopped using drugs? ___ Been injured after drinking or using? ___ Used needles to shoot drugs? |
|---|

Please continue ⇒

Name _____

ENGLISH

Date _____

Modified Simple Screening Instrument for Substance Abuse (continued)

| | Yes | No |
|---|-----|----|
| 6. Has drinking or other drug use caused problems between you and your family or friends? | | |
| 7. Has your drinking or other drug use caused problems at school or at work? | | |
| 8. Have you been arrested or had other legal problems? (Such as bouncing bad checks, driving while intoxicated, theft, or drug possession.) | | |
| 9. Have you lost your temper or gotten into arguments or fights while drinking or using other drugs? | | |
| 10. Are you needing to drink or use drugs more and more to get the effect you want? | | |
| 11. Do you spend a lot of time thinking about or trying to get alcohol or other drugs? | | |
| 12. When drinking or using drugs, are you more likely to do something you wouldn't normally do, such as break rules, break laws, sell things that are important to you, or have unprotected sex with someone? | | |
| 13. Do you feel bad or guilty about your drinking or drug use? | | |

The next questions are about your lifetime experiences.

| | Yes | No |
|--|-----|----|
| 14. Have you ever had a drinking or other drug problem? | | |
| 15. Have any of your family members ever had a drinking or drug problem? | | |
| 16. Do you feel that you have a drinking or drug problem now? | | |

Thank you for filling out this questionnaire.

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Use "✓" to indicate your answer)

| | Not at all | Several days | More than half the days | Nearly every day |
|---|------------|--------------|-------------------------|------------------|
| 1. Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| 2. Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| 3. Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| 4. Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| 5. Poor appetite or overeating | 0 | 1 | 2 | 3 |
| 6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| 8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual | 0 | 1 | 2 | 3 |
| 9. Thoughts that you would be better off dead or of hurting yourself in some way | 0 | 1 | 2 | 3 |

FOR OFFICE CODING 0 + + +
=Total Score:

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all

Somewhat difficult

Very difficult

Extremely difficult

Client Name:

Client Number:

URICA

Each statement below describes how a person might feel when stating therapy or approaching problems in his/her life. Please indicate the extent to which you tend to agree or disagree with each statement by marking an "X" in the box. In each case, make your choice in terms of how you feel right now, not what you have felt in the past or would like to feel. Make your choice in terms of how you feel right now, not what you have felt in the past or would like to feel. The words, "here" and "this place" refer to Directions for Living.

| | Strongly Disagree | Disagree | Undecided | Agree | Strongly Agree |
|---|-------------------|----------|-----------|-------|----------------|
| I am not the problem one. It doesn't make much sense for me to be here | | | | | |
| I guess I have faults, but there is nothing that I really need to change. | | | | | |
| I may be part of the problem but I don't really think I am | | | | | |
| All this talk about psychology is boring. Why can't people just forget about their problems | | | | | |
| I have worries but so does the next person, why spend time thinking about them? | | | | | |
| Being here is pretty much a waste of time for me because the problem doesn't have to do with me. | | | | | |
| I've been thinking that I might want to change something about myself. | | | | | |
| I'm hoping this place will help me better understand myself | | | | | |
| I have a problem and I really think I should work at it. | | | | | |
| I wish I had more ideas on how to solve the problem. | | | | | |
| Maybe this place will be able to help me. | | | | | |
| I hope someone here will have some good advice for me. | | | | | |
| I am finally doing some work on my problem. | | | | | |
| At times my problem is difficult, but I am working on it. | | | | | |
| I am really working hard to change. | | | | | |
| Even though I'm not always successful in changing, I am at least working on my problem. | | | | | |
| Anyone can talk about changing; I'm actually doing something about it. | | | | | |
| I am actively working on my problem. | | | | | |
| I'm not following through with what I had already changed as well as I hoped, and I'm here to prevent a relapse of the problem. | | | | | |
| I thought once I had resolved my problem I would be free of it, but sometimes I still find myself struggling with it. | | | | | |
| I may need a boost right now to help me maintain the changes I've already made. | | | | | |
| I'm here to prevent myself from having a relapse of my problem. | | | | | |
| It's frustrating, but I feel might be having a recurrence of a problem I thought I resolved. | | | | | |
| After all I had done to try to change my problem, every now and again it comes back to haunt me. | | | | | |

Client Name:

Client Number:

NATIONAL VOTER REGISTRATION ACT

Preference Form/Application

Client's preference (check the box only in 1. or 2.)

If you do not check any box, it will be considered that you chose not to register or update your voter registration at this time.

1. If you are not registered to vote where you live now, would you like to apply to register to vote today?

Yes No, I decline.

2. If you are registered to vote where you live now, would you like to update your voter registration record?

Yes No, I decline.

CLIENT: _____
Name or identification number Date

OFFICIAL USE ONLY (check all that apply)

[Note: Only a client who is eligible can decline or accept an opportunity to register or update a record on his or her behalf]

1. Client applied for: New services/assistance
 Renewal of services/assistance Address change

2. How client applied: In person By phone
 At home Online/web service

3. Client: Submitted registration application.
 Was sent form/application on ___/___/___(date).
 Did not complete application/took form/application.

Preference form must be retained by agency for two years from dated form (DS-DE 77-ENG; rev. 11-2011)

=====Notice of Rights=====

Help: If you would like help in filling out your voter registration application, we will help you. The decision whether to seek or accept help is yours. You may fill out the voter registration application in private.

Benefits: If you are applying for public assistance from this agency, applying to register, or declining to register to vote will not affect the amount of assistance you will be provided by this agency.

Privacy: Your decision not to register or update your record and the location where you applied to register or update your voter registration record is confidential and may only be used for voter registration purposes.

Formal Complaint: If you believe someone has interfered with either your right to apply to register or to decline to register to vote, your right to privacy in deciding whether to apply to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with: Florida Secretary of State, Division of Elections, NVRA Administrator, R.A. Gray Building, 500 S. Bronough Street, Tallahassee, Florida 32399-0250. Forms for filing a complaint are available at <http://election.dos.state.fl.us/nvra/index.shtml> or call 1-850-245-6200.

[Authority: National Voter Registration Act (42 U.S.C. 1973gg); sections 97.023, 97.058, and 97.0585, F.S.]

To Register to Vote in Florida, You Must:

- Be a U.S. citizen (a lawful permanent resident cannot register or vote)
- Be at least 18 years old (you may pre-register if you are at least 16 years old although you cannot vote until you are 18 years old)
- Be a Florida resident
- Have had your right to vote restored if you have ever been convicted of a felony
- Have had your right to vote restored if a court has ever declared you to be mentally incapacitated as to your right to vote.

If you do not meet these requirements, you are not eligible to register.

You Can Register to Vote at:

- Any Supervisor of Elections' office
- Any driver's license office or tax collector's office that issues driver's licenses
- Any voter registration agency (that is, any public assistance office, any office that provides services for persons with disabilities, any center for independent living, any armed forces recruitment office or any public library)
- The Division of Elections (Florida Department of State)

You Can Hand-in or Mail a Completed Application to Any of the Locations Listed Above

If mailing, mail with sufficient postage to:

Division of Elections
R.A. Gray Building
500 S. Bronough Street
Tallahassee, Florida 32399-0250

(contact information: 850-245-6200; <http://election.dos.state.fl.us>)

Your Supervisor of Elections will contact you if your application is incomplete, denied, or a duplicate.
Once you are registered, you will receive a voter information card.

*****Turn Page Over for Registration Application*****



Application to Register in Florida

Part 1 - Instructions

To Register in Florida, you must: Be a U.S. citizen, be a Florida resident and at least 18 years old (you may also pre-register if you are 16 or 17 years old but you cannot vote until you are 18).

If you have ever been convicted of a felony or if a court has ever found you to be mentally incapacitated as to your right to vote, your right to vote has to be restored before you can register.

If you do not meet any one of these requirements, you are not eligible to register.

Where to Register: You can register to vote in-person or by mailing or hand-delivering your application to any supervisor of elections' office, any office that issues driver's licenses, a ny voter registration agency (for example, any public assistance office, assisted living facility, office serving persons with disabilities, public library, or armed forces recruitment office) or the Division of Elections. *If mailing application, be sure to add sufficient postage.*

Deadline to Register: The deadline to register to vote is 29 days before an upcoming election. You can update your registration record at any time, but to change your political party for a primary election, you must make the change by the registration deadline. For a new application, you will be contacted if your application is incomplete, denied or a duplicate of an existing registration. If you receive a voter information card, that means you are registered to vote.

Identification (ID) Requirements: If you are a new applicant, state and federal law require you to provide a current and valid Florida driver's license number (FL DL#) or Florida identification card number (FL ID#). If you have not been issued a FL DL# or FL ID#, you must then provide the last four digits of your Social Security Number (SSN). If you have not been issued any of these ID numbers, check "None" on the application. If you do not provide any number or do not check "None," your registration may be denied. See s.303, HAVA and section 97.053(6), Fla. Stat.

Special ID requirements: If you are registering by mail, have never voted in Florida, and have never been issued one of the ID numbers above, you must include with your application, or at a later time before you vote, one of the following:

- A copy of an ID that shows your name and photo (*acceptable IDs*)--U.S. Passport, debit or credit card, military ID, student ID, retirement center ID, neighborhood association ID, or public assistance ID; or
- A copy of an ID that shows your name and current residence address (*acceptable documents*)--utility bill, bank statement, government check, paycheck, or other government document.

You do not have to provide the special ID to register if you are 65 or older, have a temporary or permanent physical disability, are a member of the active uniformed services or merchant marine who is absent from the county for active duty, or a family member thereof, or are currently living outside the U.S. but eligible to vote in Florida.

Political Party Affiliation: Florida is a closed primary election state. That means voters registered with a political party can only vote for that party's candidates in a partisan race on a primary election ballot. However, regardless of the political party with which you registered, you can still vote in the primary election on any issue, any nonpartisan race or any race where the candidate will face no opposition in the general election.

Indicate the political party with which you wish to be registered. If you leave the political party affiliation box blank or write "None," you will be registered without any party affiliation. For a list of political parties registered in Florida, go to the Division of Elections' website under the heading *For the Voters* at: <http://election.dos.state.fl.us/>

Race/Ethnicity: You are not required to list your race or ethnicity. However, if you choose to do so, please choose only one of the following: American Indian/Alaskan Native, Asian/Pacific Islander, Black (Not Hispanic) Hispanic, Multi-racial, White (Not Hispanic), or Other.

Public Record Notice: This application becomes a public record when filed. However, the following information is not available to the public and is used only for voter registration purposes: your FL DL#, FL ID# and SSN, where you registered to vote, and whether you declined to register or update your voter registration record when asked by a voter registration agency. Your signature can be viewed but not copied. (Section 97.0585, Fla. Stat.)

Criminal Offense: It is a 3rd degree felony to submit false information. Penalties include fines up to \$5,000 and/or up to 5 years of prison.

Questions: For more information, contact your local supervisor of elections, or refer to the Division of Elections' website at: <http://election.dos.state.fl.us/>.

Información en español. Sirvase llamar a la oficina del supervisor de elecciones de su condado si le interesa obtener este formulario en español.

Application To Register in Florida

Part 2 - Form (national mail-in application)

| | | | | | | | | | |
|---|---|--|----------|--|---------------------------------|---|-------|----------|--|
| Are you a citizen of the United States of America? Will you be 18 years old on or before election day? If you checked "No" in response to either of these questions, do not complete form. <small>(Please see state-specific instructions for rules regarding eligibility to register prior to age 18.)</small> | | | | | This space for office use only. | | | | |
| 1 | Last Name | | | First Name | | Middle Name(s) | | | |
| 2 | Home Address | | | Apt. or Lot # | City/Town | | State | Zip Code | |
| 3 | Address Where You Get Your Mail If Different From Above | | | | City/Town | | State | Zip Code | |
| 4 | Date of Birth <small>Month Day Year</small> | | 5 | Telephone Number (optional) | | 6 ID Number - (See Item 6 in the instructions for your state) | | | |
| 7 | Choice of Party <small>(see item 7 in the instructions for your State)</small> | | 8 | Race or Ethnic Group <small>(see item 8 in the instructions for your State)</small> | | | | | |
| 9 | I have reviewed my state's instructions and I swear/affirm that: <ul style="list-style-type: none"> ■ I am a United States citizen ■ I meet the eligibility requirements of my state and subscribe to any oath required. ■ The information I have provided is true to the best of my knowledge under penalty of perjury. If I have provided false information, I may be fined, imprisoned, or (if not a U.S. citizen) deported from or refused entry to the United States. | | | | | <div style="border: 1px solid black; width: 100%; height: 30px; margin-bottom: 5px;"></div> Please sign full name (or put mark) | | | |
| Date: / / | | | | | | | | | |
| If this application is for a change of name , what was your name before you changed it? | | | | | | | | | |
| A | Last Name | | | First Name | | Middle Name(s) | | | |
| If you were registered before but this is the first time you are registering from the address in Box 2, what was your address where you were registered before? | | | | | | | | | |
| B | Street (or route and box number) | | | Apt. or Lot # | City/Town/County | | State | Zip Code | |
| If you live in a rural area but do not have a street number, or if you have no address, please show on the map where you live. | | | | | | | | | |
| C | <ul style="list-style-type: none"> ■ Write in the names of the crossroads (or streets) nearest to where you live. ■ Draw an X to show where you live. ■ Use a dot to show any schools, churches, stores, or other landmarks near where you live, and write the name of the landmark. <div style="display: flex; align-items: flex-start; margin-top: 10px;"> <div style="border: 1px solid black; padding: 5px; margin-right: 10px;"> <p><small>Example</small></p> <p style="text-align: center;">Public School ●</p> </div> <div style="border: 1px solid black; padding: 5px; margin-right: 10px;"> <p style="writing-mode: vertical-rl; transform: rotate(180deg);">Route #2</p> <p style="text-align: center;">● Grocery Store</p> <p style="text-align: center;">Woodchuck Road</p> <p style="text-align: right; font-weight: bold;">X</p> </div> <div style="flex-grow: 1; border: 1px solid black; margin-top: 10px;"> <div style="display: flex; justify-content: space-between; align-items: center;"> _____ _____ </div> <div style="display: flex; justify-content: space-between; align-items: center;"> _____ _____ </div> </div> </div> <div style="text-align: right; margin-top: 10px;">NORTH </div> | | | | | | | | |
| If the applicant is unable to sign, who helped the applicant fill out this application? Give name, address and phone number (phone number optional). | | | | | | | | | |
| D | | | | | | | | | |