Directions for Living
LIFE GETS BETTER HERE

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:** _____

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

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: (check one) ☐Puerto Rican ☐Mexican ☐Cuban ☐Other Hispanic ☐Haitian ☐Mexican American ☐Spanish/Latino ☐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: _____ **Current School:** _____

Preferred Name/Nickname: _____

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

Sexual Orientation: ☐Straight or heterosexual ☐Bisexual ☐Lesbian, gay or homosexual ☐Other ☐Unknown ☐Chose not to disclose

Gender Identity: ☐Male ☐Female ☐Genderqueer ☐Transgender (MTF) ☐Transgender (FTM) ☐Other ☐Chose not to disclose

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

Total Number of persons living in household _____ **Veteran:** ☐ Yes ☐ No

Referred by: _____ **Referral Phone:** _____

Do you have an open Child Welfare case plan: ☐ Yes ☐ No

Have you ever received services here before? ☐ No ☐ Yes **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/** ☐ **PARENT/** ☐ **LEGAL GUARDIAN (check one)**

Name: _____ **Phone: Home:** _____

Address: _____ **Apt #:** _____ **Work:** _____

City/State/Zip: _____ **Relation:** _____

MEDICAL BENEFITS

Do you have any insurance? ☐ Yes ☐ No **Medicaid** ☐ **Medicare** ☐ **Commercial PPO/HMO** ☐

I authorize the release of any medical information necessary to process this or a related claim to:

_____ Member ID: _____

Insurance Company Name and Address

I authorize payment of benefits to Directions for Living.

_____ Date: ____/____/____

Client Signature

MEDICAL INFORMATION

Primary Care Physician: _____ Phone #: _____

Other Treating Physician: _____ Phone #: _____

Pain Management Specialist: _____ Phone #: _____

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 either in person, or through telehealth or telephonic.**

2) **I have received a copy of the Client Handbook, which is also available for download here http://directionsforliving.org/your_visit/ which includes information regarding:**
   - **Organizational Mission**
   - **Emergency Procedures**
   - **Client Rights and Responsibilities**
   - **Advance Directive**
   - **Notice of Privacy Practices**
   - **Infectious Disease Control**
   - **Hours of Operation**
   - **Treatment Services**
   - **Grievance Procedures**

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 consent to be contacted via phone, email, or text in regards to my appointments.**

5) **I understand that I may be contacted about my services at Directions for Living during or after services for quality improvement purposes.**

6) **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.**

7) **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**

_____ _____ _____

Parent/Guardian Signature (if applicable) **Date** **Relation to Client**

_____ _____

Witness **Date**

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: ____0____ This is your ACE Score.

Client Name: Client Number:

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: 0

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:

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Avatar URICA Stage of Change Assessment

Client Name: _____

Client ID: _____

Assessment Date: _____ **Practitioner:** _____

		1 Strongly Disagree	2 Disagree	3 Undecided	4 Agree	5 Strongly Agree
1.	As far as I'm concerned, I don't have any problems that need changing.	☐	☐	☐	☐	☐
2.	I think I might be ready for some self-improvement.	☐	☐	☐	☐	☐
3.	I am doing something about the problems that had been bothering me.	☐	☐	☐	☐	☐
4.	It might be worthwhile to work on my problem.	☐	☐	☐	☐	☐
5.	I'm not the problem one. It doesn't make much sense for me to be here.	☐	☐	☐	☐	☐
6.	It worries me that I might slip back on a problem I have already changed, so I am here to seek help.	☐	☐	☐	☐	☐
7.	I am finally doing some work on my problem.	☐	☐	☐	☐	☐
8.	I've been thinking that I might want to change something about myself.	☐	☐	☐	☐	☐
9.	I have been successful in working on my problem but I'm not sure I can keep up the effort on my own.	☐	☐	☐	☐	☐
10.	At times my problem is difficult, but I'm working on it.	☐	☐	☐	☐	☐
11.	Being here is pretty much a waste of time for me because the problem doesn't have to do with me.	☐	☐	☐	☐	☐
12.	I'm hoping this place will help me to better understand myself.	☐	☐	☐	☐	☐
13.	I guess I have faults, but there's nothing that I really need to change.	☐	☐	☐	☐	☐
14.	I am really working hard to change.	☐	☐	☐	☐	☐
15.	I have a problem and I really think I should work at it.	☐	☐	☐	☐	☐
16.	I'm not following through with what I had already changed as well as I had hoped, and I'm here to prevent a relapse of the problem.	☐	☐	☐	☐	☐
17.	Even though I'm not always successful in changing, I am at least working on my problem.	☐	☐	☐	☐	☐
18.	I thought once I had resolved my problem I would be free of it, but sometimes I still find myself struggling with it.	☐	☐	☐	☐	☐
19.	I wish I had more ideas on how to solve the problem.	☐	☐	☐	☐	☐
20.	I have started working on my problems but I would like help.	☐	☐	☐	☐	☐
21.	Maybe this place will be able to help me.	☐	☐	☐	☐	☐
22.	I may need a boost right now to help me maintain the changes I've already made.	☐	☐	☐	☐	☐
23.	I may be part of the problem, but I don't really think I am.	☐	☐	☐	☐	☐
24.	I hope someone here will have some good advice for me.	☐	☐	☐	☐	☐
25.	Anyone can talk about changing; I'm actually doing something about it.	☐	☐	☐	☐	☐
26.	All this talk about psychology is boring. Why can't people just forget about their problems?	☐	☐	☐	☐	☐
27.	I'm here to prevent myself from having a relapse of my problem.	☐	☐	☐	☐	☐
28.	It is frustrating, but I feel I might be having a recurrence of a problem I thought I had resolved.	☐	☐	☐	☐	☐
29.	I have worries but so does the next guy. Why spend time thinking about them?	☐	☐	☐	☐	☐
30.	I am actively working on my problem.	☐	☐	☐	☐	☐
31.	I would rather cope with my faults than try to change them.	☐	☐	☐	☐	☐
32.	After all I had done to try to change my problem, every now and again it comes back to haunt me.	☐	☐	☐	☐	☐

Mental Health Advance Directive

Client Name: _____ Client ID: _____

This is an advance directive. It allows you to make decisions in advance for your mental health treatment. It is important that you identify your preferences and identify friends or family you would like contacted to inform them of your hospitalization.

1. If I have to go to the hospital, I prefer to go to _____.
   I understand that my preference may not be able to be met.

2. I would like the following person identified if I am hospitalized:

   Name: _____ Phone Number: _____ Relationship: _____

_____ _____ _____
Client Signature Date Print Name

_____ _____ _____
Parent/Guardian Signature Date Print Name

_____
Relationship to Client

_____ _____ _____
DFL Provider Date Print Name

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FINANCIAL FEE FORM

Date: _____

Payment Based on:

☐ Medicare ☐ Medicaid ☐ Pin. Cty Health Plan ☐ Self-Pay/No Insurance

☐ Commercial:_____ **Name of Insurance:** _____

Client Monthly Income: $_____ Other Monthly Income: $_____

Annual Household Income: $_____

Total number of people supported by annual household income: _____

Income Verification Type:

☐ Pay Stubs ☐ Unemployment Stub ☐ W2/ 1099
☐ Letter of Support ☐ SSI Stub ☐ Self-Report
☐ Other:_____

Income verified by (Staff Name) : _____

**Income verification noted above must be copied and placed in client's record*
***To be completed quarterly except TANF which is every 30 days*

The below to be completed with FSR for AOP/COP/Medical:

Qualify for IDP: ☐ Yes ☐ No

Self-Pay $:_____ Sliding Scale %: _____

Reason for the Full Fee: _____ (Name of Insurance We Don't Accept)

Therapy Service Fees
Assessment: $ _____
Group Therapy: $ _____
Therapy: $ _____

Medical Service Fees
Psychiatric Evaluation $ _____
Medication Follow-Up Visits $_____

_____ _____
Financial Svcs. Rep. Signature Date

_____ _____
Client / Guardian Signature Date

**Please give a copy to the client and place the original in the client's file.*

Client Name: _____ Client #: _____

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 <u>one</u> 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, any 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, <u>and</u> 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? ☐ Yes ☐ No

Will you be 18 years old on or before election day? ☐ Yes ☐ No

If you checked "No" in response to either of these questions, do not complete form.

(Please see state-specific instructions for rules regarding eligibility to register prior to age 18.)

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 (Month Day Year)	5	Telephone Number (optional)	6	ID Number - (See item 6 in the instructions for your state)
7	Choice of Party (see item 7 in the instructions for your State)	8	Race or Ethnic Group (see item 8 in the instructions for your State)		

9 I have reviewed my state's instructions and I swear/affirm that:

- 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.

Please sign full name (or put mark) ➤

Date: ____ / ____ / ____ (Month / Day / Year)

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)	

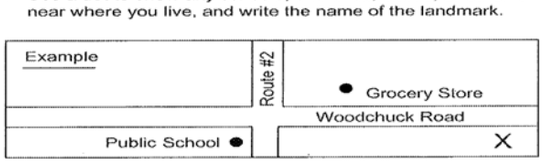
If you were **registered before but this is the first time you are registering from the address in Box 2**, what was your address where you were registered before?

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

- 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.



NORTH ➤

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