



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: ☐ 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: _____ 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:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Physically Impaired:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Non- Ambulatory:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Visually Impaired:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Deaf or Hard-of-Hearing:	<input type="checkbox"/> Yes <input type="checkbox"/> No	ADL Functioning:	<input type="checkbox"/> Yes <input type="checkbox"/> No
English Language Severely Limited:	<input type="checkbox"/> Yes <input type="checkbox"/> 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:

Insurance Company Name and Address

Member ID: _____

I authorize payment of benefits to Directions for Living.

Client Signature

Date: _____ / _____ / _____

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
 - Advance Directive
 - Hours of Operation
 - Emergency Procedures
 - Notice of Privacy Practices
 - Treatment Services
 - Client Rights and Responsibilities
 - Infectious Disease Control
 - 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



FINANCIAL FEE FORM

Date: _____

Client Name: _____ Client #: _____

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

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

Total Annual Household Income: \$ _____

Total number of people supported by above annual household income: _____

Income Verification Type Provided (if applicable):

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

Client / Guardian Signature

Date

Team Member Signature

Date

**New FFF to be completed when there are coverage changes, or at minimum annually (except TANF which is every 30 days)*

****SUBMIT COMPLETED FORM TO reimbursement2@directionsforliving.org**

To be completed by reimbursement department (reviewed with client)

Sliding Fee Scale Eligible: ☐ Yes ☐ No

Flat Rate: \$ _____ OR %: _____ Qualify for IDP (Adults only): ☐ Yes ☐ No

Calculated Fees (Copay, Coinsurance, Full-Fee, or Non-Par Provider):

Assessment: _____ (non-par) _____ Psych Eval (MD): _____ (non-par) _____
Counseling: _____ (non-par) _____ Psych Eval (APRN): _____ (non-par) _____
Group: _____ (non-par) _____ Med Management: _____ (non-par) _____

Notes: _____

Team member signature (attestation of review with client)

Date

Voter Registration Agency Form including Notices

Client's preference (check the box only in 1. or 2.)(to be completed by voter registration agency on behalf of applicant or by applicant)

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.

If no box is checked, it is considered that the client has decided not to register or if already registered, update his or her voter registration at this time.

Client's Name or ID No.:

Date: _____

OFFICIAL USE ONLY (check all that apply)

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

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

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

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

Preference forms must be retained by the agency for two years from dated form.

Notices

Eligibility Requirements

To Register to Vote in Florida, You Must:

- Be a U.S. citizen
- Be at least 18 years old (you may pre-register if you are at least 16 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.

Rights

Right to 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.

Right to 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.

Right of 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.

Right to File 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. Form DS-DE 18 is available online under the Division of Elections' Forms webpage at (<https://dos.fl.gov/elections/forms-publications/forms/>) or (850) 245-6200.

How to Submit a Voter Registration Application

If eligible to register, you can register online at www.RegisterToVoteFlorida.gov or apply:

- Through any tax collector's office that issues a Florida driver license or state ID card (in person or through their online renewal system - GoRenew.com),
- Through 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, or
- By mail or in person at your Supervisor of Elections' office and use the attached Statewide Voter Registration Application (DS-DE 39; rev. 04/24/2024). The completed application may also be mailed to the Division of Elections (Florida Department of State), R.A. Gray Building, 500 S. Bronough Street, Tallahassee, Florida 32399-0250.



Florida Voter Registration Application Instructions and Form (DS-DE 39, R1S-2.040, F.A.C.) (eff. 04/24/2024)

Información: Sírvase llamar a la oficina del Supervisor de Elecciones de su condado si le interesa obtener este formulario en español.

How to Register

- Complete and submit this form by mail or in person to:
 - Supervisor of Elections' office (mailing addresses are on back of form),
 - Any office that issues driver licenses,
 - Any voter registration agency (public assistance office, center for independent living, office serving persons with disabilities, public library, or armed forces recruitment office), or
 - The Division of Elections
- Register online: [RegistertoVoteFlorida.gov](https://registertovote.florida.gov) (or QR code).



Note: If a third-party voter registration organization (3Pvro) collects your application, the 3Pvro must give you a receipt. The 3Pvro might not deliver your application within the 10 days or by the registration deadline. You can choose instead to mail or deliver your application to your Supervisor of Elections or register online.

Voter Registration Requirements

- U.S. citizen and resident of Florida and county
- At least 18 years old (or 16 for pre-registration)
- Not adjudicated mentally incapacitated, or if so, voting rights restored.
- Not be convicted of a felony, or if so, voting rights restored.
- Do not complete this form if you do not meet all of these requirements.**

When to Register

- Deadline to register is 29 days before an election.
- Deadline to change party is 29 days before a primary election.

Registration Status

- If application is accepted, your Supervisor will mail a voter information card.
- If your application is incomplete or denied, your Supervisor will contact you.
- Contact your Supervisor if you have any additional questions.

Identification (ID) Requirements to Register or Update Record

- A current and valid Florida driver license (FL DL#), or Florida ID card number (FL ID#), or last four digits of your Social Security number (SSN).
- Special requirements apply if registering by mail for the first time, never previously voted in Florida, and never issued a FL DL or ID card or SSN. You will be required to provide identification prior to voting.

Florida has Closed Primaries/Political Party Affiliation

- You must be registered with a political party to vote in that party's primary elections. However, in primary elections, all voters can vote on nonpartisan issues and for candidates in that partisan primary race if the candidates face no opposition in the general election.
- If registering for first time and you do not choose a party, you will be registered with no party affiliation (NPA). If you are already registered and do not choose a party, your party choice on record will remain the same.

Public Record

- Most voter information, including phone number and email address is public. Your signature may be viewed but not copied.
- The following is not public: FL DL#, FL ID#, SSN, where you registered to vote, and whether you declined to register or update your voter registration record at a voter registration agency or office that issues FL DL or FL ID cards.

Resources

- Supervisor phone numbers are on back of form.
- Division of Elections: <https://dos.fl.gov/elections/>
- Voter Assistance Hotline: 1.866.308.6739
- Voter Information Lookup visit: <https://registration.elections.myflorida.com/CheckVoterStatus>

Rows 1 – 6 and 15 must be completed for an application to be processed. **Print** plainly and clearly using a black or blue pen.

☐ **New registration** ☐ **Update or change** (e.g., address, name, party affiliation, signature) ☐ **Request to replace voter information card**

1	Are you a citizen of the United States of America? <input type="checkbox"/> Yes <input type="checkbox"/> No				
2	<input type="checkbox"/> I affirm that I am not a convicted felon, or if I am, my right to vote has been restored. (For information on felon voting rights, visit Division of Elections' webpage - https://dos.fl.gov/felon)				
3	<input type="checkbox"/> I affirm that I have not been adjudicated mentally incapacitated with respect to voting or, if I have, my competency has been restored.				
4	Date of birth (mm-dd-yyyy) <div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div></div>		Florida Driver License or Identification Card Number (FL DL/ID) <div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div></div>		Last 4 of SSN (if no FL DL/ID) <div><div></div><div></div><div></div><div></div></div> <div><input type="checkbox"/> I have never been issued a FL DL/ ID or SSN.</div>
5	Last name		First name		Middle name
6	Residential address where you live in FL (no P.O. box or business address)		Unit	City	County
7	Mailing address (if different from above or mail not deliverable at residence)		Unit	City	State or country
8	Address where last registered		Unit	City	State
9	Former name (if named has changed)			Gender <input type="checkbox"/> F <input type="checkbox"/> M	State/country of birth
10	Phone no. (optional) ()		<input type="checkbox"/> Email me sample ballot if available in my county. Email address:		
11	Party affiliation (choose one) (See Florida has Closed Primaries/Political Party Affiliation above) <input type="checkbox"/> Florida Democratic Party <input type="checkbox"/> Republican Party of Florida <input type="checkbox"/> No party affiliation (NPA) <input type="checkbox"/> Minor party (print party):				
12	Race/ethnicity (choose one) <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Black, not of Hispanic Origin <input type="checkbox"/> Hispanic <input type="checkbox"/> White, not of Hispanic Origin <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Other:				
13	Military/overseas status (choose one, if applicable) <input type="checkbox"/> I am an active-duty Uniformed Services or Merchant Marine member or <input type="checkbox"/> their spouse or dependent <input type="checkbox"/> I reside outside U.S. but am a U.S. citizen				
14	<input type="checkbox"/> I will need help voting.		<input type="checkbox"/> I would like to be a poll worker or election worker		Official use only FVRS No. 3Pvro No. Agent Initials Date Collected
15	I understand that it is a 3rd degree felony under state and federal laws to falsely swear or affirm or otherwise submit false information. Oath: I do solemnly swear (or affirm) that I will protect and defend the Constitution of the United States and the Constitution of the State of Florida, that I am qualified to register as an elector under the Constitution and laws of the State of Florida, and that all information provided in this application is true.				
	Signature X		Date		