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STATE OF MISSOURI DEPARTMENT
OF MENTAL HEALTH ST. LOUIS COUNTY
REGIONAL OFFICE

9900 Page Avenue, Suite 106
ST. LOUIS, MISSOURI 63132
(314) 587-4800
(314) 877-5606 FAX
www.dmh.mo.gov

APPLICATION REQUEST
St. Louis County and St. Louis Tri County Offices

Date: _____

I am interested in applying for services with the St. Louis Regional Office. Please send me an application packet.

First Name: _____ Middle: ---------- Last: ----------
Former Last Name (maiden name):_____ D.O.B:_____

Phone # ---------- SS # ---------- Medicaid # ----------
Address:_____, City: _____, Zip Code:_____

Primary Language: ---------- Is an interpreter needed?----------

Suspected Disability: _____

Specific Needs:----------

I received special ed. services in the following school district (name and address of last school district attended):_____

_____

Name and Address of Doctor or Clinic that can document a qualifying medical diagnosis that occurred before age 22: _____

_____

(cerebral palsy, seizure disorder, head injury, autism spectrum disorder, etc...)

Please send my application and appointment date to (name, address & phone number): ____ I give

_____

permission for the person listed above to exchange information with the St. Louis Regional Office.

Printed name of applicant or legally responsible person: ----------

Legally responsible person's relationship to applicant: _____

Signature of applicant or legally responsible person: ----------

Please mail form to above address or fax to 314-877-1598

The Department of Mental Health does not deny employment or services because of race, sex, creed, marital status, religion, national origin, disability or age of applicants or employees.