Louisiana Department of Health and Hospitals
Office for Citizens with Developmental Disabilities

Request for Services Registry
Individual Information Update Form

Date: _____ Individual's name: _____

Individual's social security number: _____ Date of birth:_____

Individual's mailing address: _____
_____

Individual's physical address: _____
_____

Individual's phone numbers: _____ _____
(day time phone) (night time phone)

Name of legal guardian/family member/authorized representative: _____

Relationship to individual: _____

Legal guardian/family member/authorized representative's mailing address: _____
_____

Legal guardian/family member/authorized representative's physical address:_____
_____

Legal guardian/family member/authorized representative's phone numbers:

_____ _____
(day time phone) (night time phone)

Do you have a Medicaid card: YES NO (please circle)

Medicaid number: _____

Signature: _____