WestCON

West Central Ohio Network

ONLINE APPLICATION FOR P.L.A.Y. SERVICES

P.L.A.Y. Project/ Autism Services

County _____ Date _____

Name/ Title of Person Completing Referral _____

Address _____ City_____ State_____

Contact Information Phone #_____ E-mail_____

Applicant: Name_____ Address _____

Phone Number _____ Cell Phone _____

Date of Birth _____ Sex ( ) Male ( ) Female

Parents/Guardian Names_____

Parents Address/Phone # (If different from applicant's listed above) _____

_____

_____

Signature of Parent/Guardian *(or individual if over 18 yrs old)* / Date

_____/_____/_____

Email to **rfreer@westconcog.org** or fax to **937-492-4085** Attention: Robin Freer

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Completed by WestCON

Invoice for the following services:

_____ P.L.A.Y. Project Home Consulting, $450/mo

_____ Assessment/Evaluation, $300 _____ Other _____

Non-member County

_____ Assessment/Evaluation, $300 and mileage _____ P.L.A.Y. Project Home Consulting, $500/mo and mileage

_____ Other _____

Referral Received Date _____ Received By: _____

Home Consultant Contact Family Date _____