Accessible Communications Project (ACP) Application Form

B/Q #: _____

Enrollment#: _____

I, _____, recognize that I am providing information to Community Concepts to determine if I am qualified for the Accessible Communications Project.

Name: _____

Address: _____

Phone Number: _____

Email: _____

Date of Birth: _____

Social Security (Last 4 Only) _____

Insurance/Eligibility Qualification: _____

You are hereby absolved of any responsibility for disclosure of any information pursuant to this authorization and any liability is hereby waived. I understand that this information will be obtained and maintained in a confidential manner by representatives of Community Concepts. I also understand that this form is valid for one year from the date of this form.

_____	_____	_____
Client Print Name	Client Signature	Date
_____	_____	_____
Community Concepts Print	Community Concepts Signature	Date