

**Putnam County
Office for People with Disabilities**

110 Old Route 6, Bldg. #3
Carmel, New York 10512

Tel. 845-228-5912, Fax 845-228-6113
TTY 845-228-2386

Email: medley.broege@putnamcountyny.com
donna.santoro@putnamcountyny.com



*Robert J. Bondi, County Executive
Michael J. Piazza, Jr., Commissioner of Mental
Health, Social Services & Youth Bureau
Medley J. Broege, Coordinator
Donna Marie Santoro, M.S. Assistant Coordinator*



www.putnamcountyny.com

TODAY'S DATE: /

LAST NAME: _____

FIRST NAME: _____

MAILING: _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

HOME PHONE: _____ **BUSINESS PHONE:** _____

EMAIL ADDRESS: _____

DO YOU LIVE... **ALONE** **WITH FAMILY** **NURSING HOME OR GROUP HOME**

DATE OF BIRTH: /

LANGUAGE SPOKEN: _____ **DO YOU USE A WHEELCHAIR?** **YES** or **NO**

PLEASE EXPLAIN THE NATURE OF YOUR DISABILITY:

FOR THE PURPOSES OF DEMOGRAPHICAL DATA COLLECTION, WOULD YOU CARE TO CLAIM A RACE OR NATIONALITY? (OPTIONAL)

- | | | |
|---------------------------------------|---|--|
| <input type="checkbox"/> WHITE | <input type="checkbox"/> HISPANIC | <input type="checkbox"/> ASIAN/PACIFIC ISLANDER |
| <input type="checkbox"/> BLACK | <input type="checkbox"/> AMERICAN INDIAN/ALASKAN | <input type="checkbox"/> OTHER |

PLEASE EXPLAIN ANY NEEDS YOU MAY HAVE, WITH REGARD TO YOUR DISABILITY:

PLEASE PROVIDE THE NAME, ADDRESS AND PHONE NUMBER OF SOMEONE WHO ASSISTED YOU IN COMPLETING THIS FORM OR WHOM WE CAN CONTACT IN CASE YOU ARE UNAVAILABLE:

CONTACT NAME: _____ **CONTACT PHONE:** _____

CONTACT ADDRESS: _____

FOR OFFICE USE ONLY: Entry date: _____ DDP4 Date: _____ Registry #: _____ Initials: _____

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**Consent to Release
Information
To the**

Clearinghouse for Disabilities in Putnam County

I, _____ have been informed that there is a Central Clearinghouse
(person with a disability)
for individuals with disabilities. The purpose of the Central Clearinghouse is to ensure that people
with disabilities and their families have access to and knowledge of services and supports to meet
their needs. The Clearinghouse will be used to assist in evaluation, planning, and continuity of
services in Putnam County for people with disabilities.

I, _____ agree to have _____'s name
(Advocate or self) (person with a disability)
and individual needs submitted to Putnam County's Central Clearinghouse. I understand
this authorization covers only information required for arranging services, and that this information
will be maintained in a confidential manner and protected from further disclosure. I understand the
information in the clearinghouse will be used for collaborative planning purposes with other duly
authorized agencies and service members in the County. I understand that I have the right to cancel
my permission to release information at any time.

(Person with a disability's signature)

(Date)

(OR)

(Advocate/family member/guardian signature)

(Date)

(Address for Applicant)

(Phone #)

(Date of Birth for applicant)

Please Return This Form to:
Putnam County Office for People with Disabilities
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Carmel, New York 10512
Questions????????? Call: (845) 228- 5912