

**The Recreation Council of Greater St. Louis**  
"Advocating for Recreation Choices for Individuals with DisABILITIES"

**1:1 HIGH SUPPORT NEED VERIFICATION**

This form is completed by your St. Louis Regional Office service coordinator and sent directly to our office by fax, mail, or e-mail.

Consumer Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Consumer Address: \_\_\_\_\_

Consumer Gender:        MALE        FEMALE

1. Diagnosis of Disability: \_\_\_\_\_

2. DMH Identification Number: \_\_\_\_\_

3. Use this area to describe other circumstances regarding the consumer's physical, personal, and program needs that justify the need for a 1:1 level of support:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

This high level of support is outlined in the annual support plan: YES    NO (explain) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**ST. LOUIS REGIONAL OFFICE SERVICE COORDINATOR SIGNATURE:**

*The information I am disclosing is an accurate reflection of my client's needs.*

Service Coordinator Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Title: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

Thank you for completing this form. Your assistance is greatly appreciated. This information is used to determine eligibility for personal care funding. If you have questions, contact the St. Charles County coordinator for the Recreation Council at the number or e-mail below.

Return information:

*Mail:* Recreation Council ~ 60 Gailwood Dr – Suite C ~ St. Peters MO 63376  
*Phone:* 636-477-7704 - *Fax:* 314-726-3454  
*E-Mail:* [stchascountry@recreationcouncil.org](mailto:stchascountry@recreationcouncil.org)