Visions for Tomorrow Education
Program Attendee Application

Date ______________________

Name____

Address____

City/State/Zip____

Phone (Home) ____________________ Phone (Work) __________________
(Cell)_______________________ E-mail ________________________

Relative (Relationship) ____
For example – are you the mother, father, or caretaker (explain) of the child or adolescent with severe emotional disorder)

Age of Ill Child or Adolescent _______

Gender of Child or Adolescent_______ (F) ______(M)

Diagnosis of Child or Adolescent (if known) ___________________________

Does your relative receive?

_____Medicaid
_____Medicare
_____Both Medicaid and Medicare
_____Private Insurance
_____VA
_____Other
_____Don't know

Our classes are taught by family volunteers.

<u>Please mail this application to</u>: NAMI Greater Des Moines
Box 12174
Des Moines, Iowa 50312

<u>Or E-mail</u> the application to namigdm@gmail.com