Health Wave/Medicaid
New Student Form

USD#: ______________
Local Education Agency Name: ANW Special Education Cooperative

KIDSID#: ______________________________

Student's Name: ____
Last First M.I.

Student's Second Name: ____
(If Applicable) Last First M.I.

Gender: ☐ Male ☐ Female Date of Birth: ______________________

Social Security #: _____________________

Therapist Name: (***fill in all that apply***)

Speech Language: ____

Audiologist: ____

Occupational Therapist: ____

Occupational Therapy Assistant: ____

Physical Therapist: ____

Physical Therapy Assistant: ____

Registered Nurse: ____

Registered Nurse Attendant Care: ____

Licensed Practical Nurse: ____

Licensed Practical Nurse Attendant Care: ____

Attendant Care Provider: ____