

Mary Lee Fay  
Authorized Signature

**Number:** SPD-IM-11-035  
**Issue Date:** 4/19/2011

**Topic:** Developmental Disabilities

**Subject:** Pilot Developmental Disabilities (DD) Intake Application - DRAFT 2

**Applies to (check all that apply):**

- |   |   |
|---|---|
| <input type="checkbox"/> All DHS employees<br><input type="checkbox"/> Area Agencies on Aging<br><input type="checkbox"/> Children, Adults and Families<br><input checked="" type="checkbox"/> County DD Program Managers | <input type="checkbox"/> County Mental Health Directors<br><input type="checkbox"/> Health Services<br><input type="checkbox"/> Seniors and People with Disabilities<br><input checked="" type="checkbox"/> Other (please specify): DD eligibility specialists, brokerage directors, ODDS |
|---|---|

**Message:** SPD/ODDS has developed a new Intake Application for DD Services (refer to SPD IM-11-018). The first draft of this form was used by 5 CDDP's (listed below) between January 2011 and mid April 2011, instead of the Application or Referral for Developmental Disability Services form (DHS 2230). The first draft has been revised due to feedback from the CDDP's that are piloting the form. Attached is the revised draft of the [Intake Application for DD services](#), which meets all SPD and DD application requirements.

If a person is found to be eligible, following the submission of the Intake Application for DD Services (pilot draft, draft 2 and all future drafts), and later transfers to another County or requests brokerage services, this application (and all future drafts) shall be accepted by the receiving CDDP or Support Service Brokerage, as the application for DD services.

The CDDP's that are piloting the draft Intake Application for DD services are:

- Washington
  - Clackamas
  - Marion
  - Jackson
  - Grant/Harney/Morrow/Wheeler/Lake/Gilliam
- Brokerage, as the application for DD services.

*If you have any questions about this information, contact:*

<b>Contact(s):</b>	Chelas Kronenberg		
<b>Phone:</b>	503-945-6799	<b>Fax:</b>	503-373-7274
<b>E-mail:</b>	<a href="mailto:Chelas.a.kronenberg@state.or.us">Chelas.a.kronenberg@state.or.us</a>		



# Intake Application for Developmental Disability Services

**For Office use ONLY:**

County receiving application: \_\_\_\_\_ Date received by County \_\_\_\_\_  
 Name of person receiving application \_\_\_\_\_

Applicant Information:			
Last Name: (please print)		First Name	Middle Initial
Physical Address		City	State Zip
Mailing Address (if different)		City	State Zip
Phone number	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth	Social Security #
Applicant's Primary language	Birth Place	Marital Status	
Other Names used (birth name, maiden name, nick names)			
Email address (optional)			

<b>Are you a US Citizen or a Permanent Resident of the United States?</b> (Permanent residency applies to people lawfully admitted to the United States for permanent residence) <input type="checkbox"/> Yes <input type="checkbox"/> No      Date of Permanent Residency: _____			
Applicant's ethnicity (optional):	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Non Hispanic	
Applicant's Race: (optional)	<input type="checkbox"/> Asian	<input type="checkbox"/> African American	<input type="checkbox"/> Black
	<input type="checkbox"/> Alaskan Native	<input type="checkbox"/> Native American	<input type="checkbox"/> Native Hawaiian
	<input type="checkbox"/> Pacific Islander	<input type="checkbox"/> White	<input type="checkbox"/> Other/Unknown

Reason for application: (What services are being requested?)
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Referral person (Name)	Phone number (     )
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**Other developmental disability services:**

Have you ever applied for or received services related to developmental disabilities in the State of Oregon, or outside of Oregon?

Yes    No    If yes, which Oregon County(s) or other State(s)?

**Guardian:**

**IF APPLICANT HAS A COURT ORDERED LEGAL GUARDIAN, DOCUMENTATION OF LEGAL GUARDIANSHIP MUST BE PROVIDED AT TIME OF APPLICATION**

Does the applicant have a court ordered legal guardian?    Yes    No

If yes, name, address, phone number:

Location of Court?

**Alternate Contacts:**

Parent/Guardian name(s)	Parent/Guardian phone number
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Parent/Guardian address	Parent/Guardian email address
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Emergency contact name	Emergency contact phone number
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Emergency contact address	Emergency contact email address
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What is your relationship to your emergency contact?

Additional information/ comments:

**Disabilities: Complete all that applies:**

Condition	Briefly describe current function and support, specific diagnoses, etc.
Intellectual Disability/Mental Retardation	
Cerebral Palsy	

Autism Spectrum Disorder	
Down Syndrome	
<b>Disabilities (continued): Complete all that applies</b>	
Epilepsy	
Motor issues	
Communication	
Vision impaired	
Hearing impaired	
Mental/emotional/behavioral	
Traumatic Brain Injury/Acquired Brain Injury	
Prenatal exposure to drugs, alcohol or other toxins	
Delayed milestones (explain)	
Other disability	
Other disability	
Additional Comments:	

<b>Legal:</b>	
Does applicant have a criminal/juvenile court record? <input type="checkbox"/> Yes <input type="checkbox"/> No	
State/County of offense:	Offenses:
Parole/Probation contact name:	Contact phone number: (     )     -

<b>Educational History:</b> (Did applicant receive special education (i.e Early intervention, IEP or 504 plan?))
Most recent/current school

Previous school (if applicable)		Special education services ever received? <input type="checkbox"/> Yes <input type="checkbox"/> No
Did applicant graduate from high school?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Year graduated or last grade completed:
What type of diploma was received?	<input type="checkbox"/> Regular <input type="checkbox"/> Modified <input type="checkbox"/> GED <input type="checkbox"/> None <input type="checkbox"/> Certificate of completion	
<b>Current Living Situation:</b> (examples: with family, alone, with friends, foster care, group home, psychiatric hospital, nursing home)		
Describe current living situation:		
<b>History of Living Situations:</b> Prior to the current living situation, have you lived anywhere else outside your own home or family home (examples: foster care, group home, nursing home, residential treatment facility, psychiatric hospital, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe:		
<b>Financial Resources:</b> (Relates only to the applicant)		
Is applicant currently receiving, or have they ever applied for, financial resource? (SSI, SSDI etc) <input type="checkbox"/> Yes <input type="checkbox"/> No		
SSI amount		
Social Security amount		
Other		
Does applicant need to be referred to Social Security to apply for benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Representative Payee name		Phone number
<b>Health Insurance:</b> (Complete those that apply.)		
<u>Existing Coverage:</u>	<input type="checkbox"/> <i>Oregon Health Plan #:</i> _____  <input type="checkbox"/> <i>Medicare #:</i> _____	<i>Private health insurance carrier:</i> _____  <input type="checkbox"/> <i>None</i>
Does applicant need assistance applying for Medicaid/Oregon Health Plan? (food stamps, health insurance) <input type="checkbox"/> Yes <input type="checkbox"/> No		

**Other Service Agencies:** Current and previous (examples: child welfare, self sufficiency, vocational rehabilitation, mental health)

Agency Name:	Contact /Representative's Name:	Phone:	Dates:
		( )	
		( )	
		( )	

**Medical/Dental:** (primary care physician, dentist and preferred hospital)

Primary Care Physician name:	Address	Phone number

Dentist name:	Address	Phone number

Preferred hospital:	Address:	Phone:

**Medical Specialists:** (examples: psychologist, psychiatrist, neurologist, developmental pediatrician, etc.)

Name & Specialty:		Phone:	
		( )	
Address:	City:	State:	Zip Code:
Name & Specialty:		Phone:	
		( )	
Address:	City:	State:	Zip Code:

**Other Information:**

Have any tests or special evaluations been completed in the past? Yes  No

If you have had evaluations completed in the past, which agencies arranged the evaluation?  
(examples: Social Security, Vocational Rehabilitation, college, private pay, primary care physician)

Name of agency	Contact name (if known)	Phone number
Name of Agency	Contact name (if known)	Phone number
<b>Are there any other agencies that hold records about your disability?</b>		
Name of agency	Contact name (if known)	Phone number

<b>Notification of eligibility determination:</b>
In addition to receiving a copy of the eligibility determination notice in the mail, is there another way that you would like to be notified of the eligibility determination? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please explain:
<b>If you would like a copy of the eligibility determination notice sent to anyone besides yourself, you must provide the name and address of this person in the space above. A release of information <u>must</u> be on file in the developmental disability office in order to provide this information to anyone other than the applicant and/or legal guardian.</b>

- Services from the Community Developmental Disabilities Program (CDDP) have been requested.
- An eligibility determination will be made within 90 days of the CDDP receiving this application.
- An extension of up to 90 days, for the CDDP to make an eligibility determination, may be mutually agreed upon under certain circumstances.
- A contested case hearing may be requested if the eligibility determination is dissatisfactory.
- A contested case hearing may be requested by legal counsel, a relative, a friend or other spokesman.
- A hearing must be requested within 45 days of being notified of the eligibility determination in accordance with OAR 411-320-0175
- A request for a contested case hearing must be made on DHS form 0443DD

**Signatures** By signing below, I agree that the information is true and correct whether give by me or by someone else.

Name of person completing the Application (if other than the applicant or legal guardian)	Phone:
Applicant's Signature (or legal guardian):	Date:
Name (print):	

**Discrimination statement:** *The Department of Human Services (DHS) will not discriminate against anyone. This means DHS will help all who qualify. DHS will not deny help to anyone based on age, race, color, national origin, sex, sexual orientation, religion, political beliefs or disability. You can file a complaint if you think DHS discriminated against you because of any of these reasons. To file a complaint, please read the "Client Discrimination Complaint Information" (DHS 9001) or call the U.S. Dept of Health & Human Services at 1-800-537-7697.*