INTRODUCTION TO THE APPLICATION FOR SERVICES

By completing this application, you are requesting services from the Rhode Island Division of Developmental Disabilities. Participation is voluntary; you may withdraw this request at any time.

See the Checklist on page 3 for the list of required documents. Without these documents, and a signed application, your application will be considered incomplete and we will not be able to initiate the application review process. Please note that the applicant and/or their legal guardian must sign ALL forms. If the applicant is unable to sign their name, they must make a mark on the signature line and have it witnessed by a friend or family member.

CRITERIA TO RECEIVE BHDDH-FUNDED SERVICES

There are 2 requirements in order to receive BHDDH-funded services. You must:

1. Be eligible for BHDDH services by having an intellectual disability since birth or before age 22, or another type of developmental disability which requires services similar to those needed by people with an intellectual disability. See Eligibility Criteria below for more details.

2. And be found Medicaid eligible by the Department of Human Services.

ELIGIBILITY CRITERIA

To be eligible for supports funded through the Division of Developmental Disabilities individuals must have an Intellectual Disability or meet the following definition of developmental disability, as stated in RI State Law: The term 'developmental disability' means a severe, chronic disability of a person which:

- is attributable to a mental or physical impairment or combination of mental and physical impairments;
- is manifested before the person attains age twenty-two (22);
- is likely to continue indefinitely;
- results in substantial functional limitations in three or more of the following areas of major life activity:
  1. personal care 5. self-direction
  2. communication 6. capacity for independent living
  3. mobility 7. economic self-sufficiency;
  4. learning
- and reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment or other services which are life-long or of extended duration and are individually planned and coordinated.
SUBMISSION

Mail completed applications and all other documents to:

BHDDH-DDD
Simpson Hall, Eligibility Unit
6 Harrington Rd
Cranston, RI 02920

Keep a copy of all documents for your records. The Division of Developmental Disabilities (DDD) will send confirmation when the COMPLETED application is received. If an application is incomplete, you will receive a letter listing what is missing and how long you have to submit the missing documents.

ELIGIBILITY DETERMINATION

Complete application packets with all required documents (see Checklist on page 3), will be processed within 30 days. Once the Eligibility Committee has made a determination, a notice of the determination will be sent to the applicant. If the applicant has a legal guardian(s), they will also be notified, and, when appropriate, the agency, advocate, or professional who referred the applicant.

If the applicant is eligible, the letter will describe next steps. If the applicant is found ineligible, the notice will include the reasons for the determination and an explanation of the applicant’s appeal rights. If a determination cannot be made, an in-person interview will be set up.

QUESTIONS

If you have any questions while completing these forms, please call the Division of Developmental Disabilities (DDD) at 401-462-3421 and ask to speak with the covering eligibility caseworker.

Please note that DDD cannot begin the eligibility determination process if any information is missing or incomplete.
**CHECKLIST OF DOCUMENTS TO BE SUBMITTED WITH THIS APPLICATION**

The documentation listed in both boxes is needed to determine eligibility for services through the Division of Developmental Disabilities. Applicants who do NOT have a clear diagnosis of an Intellectual Disability will be assessed based on how the individual’s disability significantly impacts functional abilities.

**Before submitting your application:**

- Remember to sign the Application form. Only Applications that have been signed can be processed.
- Make sure all documentation is attached.

### General Documentation

- Copy of Applicant’s **Birth Certificate or I-94 form**
- Copy of Applicant’s **Social Security Card**
- Copy of **Medicaid and/or Medicare Card**
- Proof of **Rhode Island Residency**
  
  *Acceptable documentation will be current and show name and address (no PO Box). This includes: a voter registration card, utility bill, bank statement, payroll check stub, tax records, lease, or current school records with the student’s address, including a report card, diploma, transcript or ID card, together with parent’s license/ID with same address.*

- If applicable, a copy of the **Probate Court’s Appointment of Guardianship** paperwork or **Power of Attorney**

### Disability Related Documentation

- **Official DSM Diagnosis** by medical doctor, psychologist, or licensed clinician, such as Down Syndrome, Fragile X Syndrome, or Intellectual Disability *(Please submit all diagnoses)*
- **Intelligence/Cognitive Tests:** These tests, such as the Wechsler or Stanford-Binet, assess the applicant’s intellectual/cognitive ability and generate IQ scores *(Please submit all available tests)*
- **Vocational records** through school, Office of Rehabilitative Services, or other agency

If applicable, also submit the following documentation:

- **Medical history** and most recent physical examination records documenting a medical disability
- **Psychiatric records** including any psychiatric hospitalizations
- Any other agency records that document the applicant’s abilities and limitations, including but not limited to CEDARR, PASS, HBTS reports, or school testing such as OT or PT
RHODE ISLAND DEPARTMENT OF BEHAVIORAL HEALTHCARE, DEVELOPMENTAL DISABILITIES & HOSPITALS
DIVISION OF DEVELOPMENTAL DISABILITIES

APPLICATION FOR SERVICES

SECTION 1. PERSONAL INFORMATION

Applicant Name: ____________________________ Gender: □ M □ F

Social Security Number: ____________________________ Date of Birth: ____________________________

Residence Address: ____________________________ Mailing Address (if different):

Street: ____________________________ Street/PO Box: ____________________________

Apt: ____________________________ Apt: ____________________________

City, State Zip: ____________________________ City, State Zip: ____________________________

Telephone: ____________________________ Email: ____________________________

Living Arrangements: □ Live Alone □ With Family □ Group Home/Residential □ Other

School Information

□ Applicant has graduated or left school.
□ Applicant is still attending school or receiving any school funded service.

Anticipated date of final school supported services: ____________________________

School/Transition Program: ____________________________

School Contact Person: ____________________________ Phone#: ____________________________

Other Services

Are you receiving services from: □ CEDARR □ ORS
□ HBTS □ DCYF
□ PASS

Applicant’s Disability/Disabilities

Please note, disability must have occurred before your 22nd birthday.

Age when disability/disabilities began: ____________________________

Do you have an official diagnosis of an Intellectual Disability that has been determined by evaluation by a licensed psychologist or other licensed professional? □ Yes □ No

List all official diagnosis, and attached supported documentation as listed in checklist on page 3.

________________________

________________________

________________________

________________________
**Court-Appointed Guardian or Power Of Attorney**

Do you have a court appointed guardian?  □ Yes  □ No

Do you have a power of attorney         □ Yes  □ No

If "Yes", complete the information below

☐ Enclose a copy of the Probate Court’s Appointment of Guardianship paperwork or
   Power of Attorney document

Name of Guardian 
or Person with POA: ________________________________

Relationship: ___________________________ Telephone: ________________________

Address: ________________________________________________________________

City, State Zip: __________________________________________________________

---

**SECTION 2: SERVICES REQUESTED THROUGH THE DIVISION OF DEVELOPMENTAL DISABILITIES**

Describe the type of services or supports you believe you need (a service could be a Job Coach; and support could be “help getting a job”). For example: Do you need help with getting a job? Do you need assistance to get dressed? Do you need family support? Do you need some place to live?

________________________________________________________

________________________________________________________

________________________________________________________

________________________________________________________

☐ **Case Management** – Services of a Social Worker through the Division to assist in accessing supports.

☐ **Employment Supports** – Supports to find and keep a job.

☐ **Day Supports** – Supports to assist with volunteer experiences or recreational and social activities.

☐ **Community Supports** – Direct support and assistance for participants for recreational and social activities, or for the relief of the caregiver, in or out of the participant’s residence.

☐ **Home Modifications** – Changes in the home to enhance the individual’s ability to be independent.
SECTION 3: FUNCTIONAL INFORMATION
If the applicant is over the age of 21, please complete the following section for his/her abilities at age 21.

A. Do you have an official diagnosis of an Intellectual Disability (formerly MR)?
   - Yes ➔ Go to Section 4
   - No ➔ Complete B – H Below

Please note the following definitions:
- NONE = No assistance needed, independent with task
- PROMPTING = Verbal reminders to initiate or for thoroughness
- DIRECT = Physical assistance or total support needed

B. LEARNING

<table>
<thead>
<tr>
<th>In school did you have an IEP?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you able to read a newspaper?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>What books or magazines do you read?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you able to tell time?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>If yes, with an analog (clock with a face and hands) or digital (numbers only, like 3:47 PM) clock?</td>
<td>Analog</td>
<td>Digital</td>
</tr>
<tr>
<td>Do you have sensory issues? If yes, please describe:</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

C. SELF CARE
dressing, eating, grooming, hygiene

<table>
<thead>
<tr>
<th>Activity</th>
<th>None</th>
<th>Prompting</th>
<th>Direct</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bathing:</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Tooth brushing:</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Hair washing:</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Toileting:</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Dressing:</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Eating:</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Please explain the areas where you need prompting or direct assistance:
**D. EXPRESSIVE/RECEPTIVE LANGUAGE**
*talking to other people / understanding what they say to you*

Are you able to understand other people when they talk to you?  
☐ Yes  ☐ No

Do you need any special help to communicate with people who don’t know you well? (for example, sign language, communication device, pictures, or does someone you know “interpret” what you mean). If yes, please describe:  
☐ Yes  ☐ No

**E. MOBILITY**
*walking / getting around / motor skills*

Do you need any special equipment to help you get around?  
☐ Yes  ☐ No

Are you able to independently go up and down stairs?  
☐ Yes  ☐ No

Are you able to fasten buttons?  
☐ Yes  ☐ No

Are you able to fasten zippers?  
☐ Yes  ☐ No

Are you able to use a pencil or pen?  
☐ Yes  ☐ No

**F. SELF-DIRECTION**
*making your own decisions*

Do you have a representative payee for SSI/SSDI checks?  
☐ Yes  ☐ No

What bills do you pay on your own?

How do you pay these bills (check, credit card, pay at site)?

Who helps you with your goals and big decisions (moving, new job, etc.)?

Does anyone help you with day to day planning/activities? If so how?  
☐ Yes  ☐ No

List clubs or organizations you belong to:

Are you able to keep in touch with friends on your own?  
*(phone them or otherwise contact to make plans to get together)*  
☐ Yes  ☐ No

Do you need help to get out of your home in case of emergency?  
*If yes, please describe:*  
☐ Yes  ☐ No
How long are you comfortable being home alone?

List two reasons to call 911:
1. 
2. 

Do others sometimes take advantage of you (borrow money and not pay you back or take your belongings)? If yes, what do you do? Yes No

What would you do if a stranger is bothering you?

G. INDEPENDENT LIVING
living on your own

Meal Preparation:
What kind of help do you need to use the following kitchen appliances:

<table>
<thead>
<tr>
<th>Activity</th>
<th>None</th>
<th>Prompting</th>
<th>Direct</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stove:</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Microwave:</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Dishwasher:</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Hand Wash Dishes:</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

Please explain the areas where you need prompting or direct assistance:

Are you able to make a grocery list? Yes No
Are you able to read and follow a recipe? Yes No

Describe food items that would make a healthy meal:

Describe the help you would need to prepare this meal:
Household Chores:
What kind of help do you need to do the following household chores:

<table>
<thead>
<tr>
<th>Activity</th>
<th>None</th>
<th>Prompting</th>
<th>Direct</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vacuuming</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Laundry</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Changing Bedding</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Sweeping and Mopping</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Cleaning a Bathroom</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Please explain the areas where you need prompting or direct assistance:

Errands and Appointments:
What kind of help do you need in the following areas:

<table>
<thead>
<tr>
<th>Activity</th>
<th>None</th>
<th>Prompting</th>
<th>Direct</th>
</tr>
</thead>
<tbody>
<tr>
<td>Riding the RIPTA Bus</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Shopping (Food, Clothes)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Setting Appointments</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Getting to Appointments</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Following Doctor’s Orders</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Taking Medication</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Please explain the areas where you need prompting or direct assistance:

If you buy something in a store, do you count your change? ☐ Yes ☐ No
Can you tell if the change is the correct amount? ☐ Yes ☐ No
If you go to the store with $14.00 and spend $5.00, how much will you have left? ____________
How many quarters are in $1.75? ____________
What are your current medications?
H. ECONOMIC SELF-SUFFICIENCY

Work

What kind of help do you need in the following areas:

<table>
<thead>
<tr>
<th>Activity</th>
<th>None</th>
<th>Prompting</th>
<th>Direct</th>
</tr>
</thead>
<tbody>
<tr>
<td>Locate a job &amp; complete application:</td>
<td>☐</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>Participate in basic job interview:</td>
<td>☐</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>Learn the job:</td>
<td>☐</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>Return from break on time:</td>
<td>☐</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>Accept correction:</td>
<td>☐</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>Working with others:</td>
<td>☐</td>
<td>☐</td>
<td>☑</td>
</tr>
</tbody>
</table>

Please explain the areas where you would need prompting or direct assistance:

List any paid jobs you have held (past or present):

List any volunteer jobs you have held (past or present):
SECTION 4: RELEASES

HIPAA Release

Name: __________________________ Date of Birth: ___/___/____

Release of Information
I authorize the release of information including educational, medical, psychological, vocational, and other records that will assist the Division of Developmental Disabilities in the eligibility determination process. This information may be released to the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals, Division of Developmental Disabilities.

This Release of Information will remain in effect for 1 year from the date signed unless terminated by me in writing earlier.

Messages
Please call:
- my home
- my work
- my cell number: __________________

If unable to reach me:
- you may leave a detailed message
- please leave a message asking me to return your call
- ______________________________

The best time to reach me is (day)___________________ between (time)___________________

Signed: __________________________ Date: ___/___/____

Witness: __________________________ Date: ___/___/____

Notification Of Eligibility Decision
If you would like a copy of the BHDDH eligibility decision notice sent to anyone besides yourself, you must provide the name and address of the person below. This serves as written authorization to allow BHDDH to release information and to send a notice to anyone other than the applicant or legal guardian.

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship to applicant (e.g., guardian, representative)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>City</td>
</tr>
</tbody>
</table>

BHDDH Application for Eligibility 09/29/17
### SECTION 5: DEMOGRAPHICS AND OTHER INFORMATION

#### Demographic Information

<table>
<thead>
<tr>
<th>Racial/Ethnic Heritage:</th>
<th>White (non-Hispanic)</th>
<th>Black (non-Hispanic)</th>
<th>Hispanic</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Asian/Pacific Islander</td>
<td>American Indian/Alaskan Native</td>
<td>Other</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Marital Status:</th>
<th>Never Married</th>
<th>Married</th>
<th>Divorced</th>
<th>Separated</th>
<th>Widowed</th>
</tr>
</thead>
</table>

#### Parent/Caregiver Information:

Parent/Caregiver Name and Date of Birth: 

Parent/Caregiver Name and Date of Birth: 

#### Preferred Communication Format

I prefer to receive information via:  

- [ ] Regular Mail  
- [ ] Email  

In what language do you want us to speak with you? 

In what language do you want us to write to you? 

Do you need an interpreter (including sign language)? 

Other communication needs: 

#### Medical Insurance

Do you have Medicaid?  

- [ ] Yes  
- [ ] No  

*If yes, Medicaid #:*

Do you have Medicare?  

- [ ] Yes  
- [ ] No  

*If yes, Medicare #:*

Other Health Insurance: 

Primary Physician/Health Care Provider Name: 

Address: 

Telephone: 

#### Source of Income

Do you receive:

- SSI:  
  - [ ] Yes  
  - [ ] No  
  - Amount per Month: $

- SSDI:  
  - [ ] Yes  
  - [ ] No  
  - Amount per Month: $

- RSDI:  
  - [ ] Yes  
  - [ ] No  
  - Amount per Month: $

Other Income Source:  

- Amount per Month: $

SECTION 6: SUBMISSION

Did You Need Help In Completing This Form? □ Yes □ No

If "Yes", who helped you complete it?

Name: ____________________________________________________________

Relationship: ___________________________ Telephone: _______________________

I give permission to BHDDH to discuss my application and records with the person named above for the purpose of completing the eligibility determination process.

Please send this application and copies of all required records to BHDDH. Mail to:

BHDDH-DDD
Simpson Hall, Eligibility Unit
6 Harrington Rd
Cranston, RI 02920

You will receive an email or letter confirming the receipt of this application.

Signature

By signing below, I agree that the information contained in this application is true and correct, whether given by me or a representative.

<table>
<thead>
<tr>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Print name

Relationship

□ Self (adult applicant)

□ Adult’s court-appointed guardian

□ Minor’s custodial parent or legal guardian