



STATE OF RHODE ISLAND AND PROVIDENCE PLANTATION
 BEHAVIORAL HEALTHCARE, DEVELOPMENTAL DISABILITIES, AND HOSPITALS
 DIVISION OF DEVELOPMENTAL DISABILITIES
 6 HARRINGTON ROAD – SIMPSON HALL
 CRANSTON, RI 02920
 (401) 462-3421

APPLICATION FOR SERVICES

Internal Use Only

1. PERSONAL INFORMATION:

Applicant's Name: _____ **Date of Birth:** _____

Residence Address: _____
 Street Apt./Floor City State Zip

Mailing Address: _____
(if different from residence) Street/PO Box Apt./Floor City State Zip

Telephone: _____ **Social Security #:** _____

Email Address: _____ **Gender:** Male Female

I prefer to receive information via - email regular mail

DCYF involved: Yes No **Final date of school funded services:** _____

Marital Status: Never Married Married Divorced Separated Widowed

Maiden Name: *(if applicable)* _____

Racial/Ethnic Heritage: White (non-Hispanic) Black (non-Hispanic) Hispanic

Asian or Pacific Islander American Indian or Alaskan Native Other

Do you or any member in your household speak English? Yes No *If "No", what is the primary language spoken?* _____

Living Arrangement: Live Alone With Family Group Home/Residential Other

Parent/Caregiver's Name and Date of Birth: _____

Parent/Caregiver's Name and Date of Birth: _____

Name of Primary Physician/Health Care Provider: _____

Address: _____ Telephone: _____

Medicaid: Yes No Medicare: Yes No Other Health Insurance: _____

2. PLEASE INDICATE APPLICANT'S DISABILITY/DISABILITIES:

(Please provide disability names and/or descriptions)

Age When Disability/Disabilities Began: _____

3. SOURCE OF INCOME: Please provide recent work information.

Are You Currently Employed? Yes No If 'Yes', please provide the employer's name and address below:

Applicant's Gross Pay:
(please indicate one)

Annual \$ _____
(amount earned per year)

Bi-Weekly \$ _____
(amount earned every two weeks)

Weekly \$ _____
(amount earned every week)

Does the applicant receive:

SSI: Yes No Amount per Month \$ _____
(government check on 1st of month)

SSDI/RSDI: Yes No Amount per Month \$ _____
(government check on 3rd of month)

Other income source: Amount Per Month \$ _____
(e.g. child support, alimony, trust fund. Etc.)

4. SERVICES REQUESTED THROUGH THE DIVISION OF DEVELOPMENTAL DISABILITIES:

- Case Management** – Services of a Social Worker through the Division to assist in accessing supports.
- Employment/Day Supports** – Supports to assist the individual in supported employment, volunteer experiences, or recreational and social activities.
- Community Supports** – Direct support and assistance for participants, or for the relief of the care giver, in or out of the participant’s residence.

Residential Supports:

- Immediate residential services** BHDDH - QI involvement due to abuse or neglect, police, attorney general’s office or DCYF decision that warrants a removal and placement in residential setting, individuals in hospitals or time-limited rehab requiring 24 hr residential setting at discharge, youth in residential setting when turning 21, medically fragile primary caretaker, temporary setting follow the incapacitation or death of primary caretaker.
- Future residential services.** Individual may need or want residential services in the future.
- Home Modifications** – Changes in the home to enhance the individual’s ability to be independent.
- Assistive Technology** – Devices to assist the individual with personal care, communication and mobility.

6. DO YOU HAVE A COURT-APPOINTED GUARDIAN? Yes No

If "Yes", please complete the information below as well as enclose a copy of the Probate Court’s Appointment of Guardianship paperwork

Name: _____ Relationship: _____ Telephone: _____

Address/City/State/Zip: _____

7. DID YOU NEED HELP IN COMPLETING THIS FORM? Yes No If "Yes":

Name: _____ Relationship: _____ Telephone: _____

8. DO YOU WANT SOMEONE WITH YOU DURING AN INTERVIEW WITH THE DIVISION’S STAFF? Yes No If “Yes” and the person you’d like with you during the Division’s staff interview is different than the person listed above, please provide his/her name, relationship, and telephone number below:

Name: _____ Relationship: _____ Telephone: _____

Please include records that document your disability. This documentation should include:

Please note, disability must have occurred before age 22 and behavioral health diagnosis are not considered a developmental disability

- Cognitive testing (available through schools w/in 7 years of attendance or private testing through medical coverage)
- Official diagnosis by medical doctor, psychologist, or licensed clinician – all diagnosis available should be submitted
- Vocational records through school, ORS, or other agency.
- Medical records that document medical disability, if applicable.
- Psychiatric records including any psychiatric hospitalizations, if applicable.
- Any other agency records that document the applicant’s abilities and limitations.

*Often multiple evals and diagnosis are available. Please submit all available records.

Please choose one of the following:

- All available records are included**
- I need additional time to gather records/documentation**

Please send this application, along with the Functional Information Report, and a copy of any records you already have to BHDDH.

Mail to:

BHDDH – Simpson Hall
6 Harrington Rd
Cranston, RI 02920

*We will send you an email or letter confirming the receipt of this application.