**Intellectual Disabilities Services Request**

**Purpose**: This form is to request disability support services for adults with diagnosed developmental disabilities.

The Department on Disability Services (DDS) provides a variety of supports and services to assist people with disabilities in leading self-directed lives. People with intellectual disabilities has access to services and supports through: natural home supports, community resource services, service coordination, state plan services, and services provided through the Home Community Based Services Waiver (HCBS).

In addition, the agency also offers independent living services, vocational rehabilitation services, services for the blind and visually impaired, youth transition services, and supported employment.

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| **Eligibility:** You must meet all 3 requirements to receive services.  🗹 ≥ 18 years old 🗹 DC resident 🗹 Intellectual Disability with ≥ 2 challenges in adaptive functioning |

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| **Submission Instructions**  **1 Complete page one and two**  **2 Attach the following (required):**  𝥷Birth certificate or state ID (copy)  𝥷Social security card (copy)  𝥷Proof of DC residency (current lease or utility bill, or official statement from Social Security)  **3 Attach the following (if available):**  𝥷Psychological evaluations documenting that the person has an intellectual disability  𝥷Psychological evaluations documenting that the person has two adaptive functioning deficits  𝥷Current physical or medical form from doctor  **4 Submit the form and attachments one of the following ways:**   * **Email** to [generaladdress@dc.gov](mailto:generaladdress@dc.gov) * **Mail** to Department on Disability Services 250 E Street, SW, Washington, DC 20024. * **Bring in-person** to either:   + DDS: 250 E Street, SW, Washington, DC 20024 | Mon - Fri 8:15am-4:45pm.   + Aging and Disability Resource Center: 500 K Street, NE, Washington, DC 20002 | Mon - Fri 8am - 5pm. |

**Application**

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| **Person For Whom Benefits are Requested** |

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_

Full Name

Telephone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Washington, DC \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Number and Name Zipcode

Does the person have Medicaid? 𝥷Yes, the # is \_\_\_\_\_\_\_\_\_\_\_\_\_ 𝥷No, the person needs help registering

You must be enrolled in Medicaid to receive services.

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| **Guardian/Family Member** |

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Person \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Full Name

Telephone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Street Number and Name City State Zipcode

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| **If an Outside Organization is Making the Referral** |

Referral Organization 𝥷CSFA 𝥷DCPS 𝥷SCSN 𝥷Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referrer Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Full name

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| **Signature** |

The statements above are accurate to the best of my ability. I declare them to be true. Any significant changes in these circumstances will be made known immediately.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of applicant or parent/guardian Date

**You will be notified about your request within 45 calendar days.**

**Consent to Obtain or Release Record Information**

DDS may need additional information to develop an appropriate service plan for the person. By completing this form you are allowing DDS to contact doctors and/or organizations on your behalf.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ residing at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person’s Full Name Date of Birth Address - Street Number and Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Washington, DC \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Zipcode

**Hereby requests that the following information:** *check all that apply*

𝥷Individual Support Plan

𝥷Behavior Support Plan

𝥷Health Record

𝥷Health Care Management Plan

𝥷Level of Need

𝥷Psychological

𝥷Provider Documentation

𝥷Labs/Clinical/Health Data

𝥷Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

𝥷Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Be disclosed by:**

What are the 3 most-likely organizations or doctors that might have copies of the person’s psychological evaluations? (e.g. past K-12 schools, doctors, service agencies, Medicaid, Social Security, etc.)

Name/Organization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(For schools or agencies, list the city & state. For doctors, list phone number)

Name/Organization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(For schools or agencies, list the city & state. For doctors, list phone number)

Name/Organization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(For schools or agencies, list the city & state. For doctors, list phone number)

**To:** Potential Residential Service Providers/Day Habilitation Service Providers; solely for the purpose of: consideration for determination of ability to provide Residential Services/Day Habilitation Services to apply both now and in the future. This consent expires one year from the date of signing. Pursuant to the District of Columbia Mental Health Information Act of 1978 as amended (d.c. official code § 7-1201.01 et seq., specifically § 7-1202.01), the Mentally Retarded Citizens Constitutional Rights and Dignity Act of 1978 as amended (d.c. official code § 7-1301.01 et seq., specifically § 7-1305.12), the Health Insurance Portability and Accountability Act of 1996 as amended (pub. l. 104-191), and other local and federal privacy acts; I voluntarily consent for the Department on Disability Services to obtain or release record information for the purpose stated above. I understand that this consent can be revoked by me in writing at any time. I understand that this information may not be redisclosed without my permission.

**Signed:** *check one* 𝥷Person 𝥷Legal Guardian 𝥷Durable Power of Attorney

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name Signature Date

**Explained by:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Agency provider or representative Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title Phone number