South Dakota Division of Developmental Disabilities
Application for Services

Reason for Referral: _____

Applicant Name: _____
(First) (Middle) (Maiden) (Last)

Date of Birth: _____ Sex: ☐ Female ☐ Male

Current Address: _____
(Street) (City) (State) (Zip)

Permanent Address: _____
(Street) (City) (State) (Zip)

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____

Family Contact: _____
(First) (Middle) (Last) (Type of Relationship)

Address: _____
(Street) (City) (State) (Zip) (Email address)

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Additional Contact: _____
(First) (Middle) (Last) (Type of Relationship)

Address: _____
(Street) (City) (State) (Zip) (Email address)

Home Phone: _____ Work Phone: _____ Cell Phone: _____

SCHOOL INFORMATION – Check all that apply

☐ Currently attending school — Date school services projected to end: _____
☐ Graduated with signed diploma — Date school services ended: _____
☐ Received certificate of completion — Date school services ended: _____

School: _____ Contact Person: _____ Phone: _____

LEGAL REPRESENTATIVE/CONSERVATORSHIP – Check all that apply to the applicant if over 18 years old.

☐ Court Ordered Legal Representative and type (medical, limited, etc.): _____
☐ Court Ordered Conservator and Name if different from Legal Representative: _____
☐ Power of Attorney and type: _____
☐ No Legal Representative in place. ☐ Copies of Legal Documents are attached.

Legal Representative's Name: _____
(First) (Middle) (Last)

Address: _____
(Street) (City) (State) (Zip) (Email address)

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Home Phone:_____ Work Phone: _____ Cell Phone:_____

SERVICES REQUESTED – Check all that apply

☐ **Educational Services** Requested Start Date:_____
- ☐ Integrated Classroom
- ☐ Self-Contained Classroom

☐ **Employment Services** Requested Start Date:_____
- ☐ Day Services
- ☐ Supported Employment
- ☐ Community Employment
- ☐ Own my Own Business

☐ **Residential Services** Requested Start Date:_____
(i.e., independent living skills, community living skills, financial, personal living, etc.)

- ☐ Live with family
- ☐ Live alone
- ☐ Live with roommate
- ☐ Group Home
- ☐ Supervised apartment
- ☐ Rent apartment or home
- ☐ Buy house
- ☐ 24 hr. support needed
- ☐ Daily support needed
- ☐ Weekly support needed
- ☐ Other_____

DEVELOPMENTAL DISABILITY DIAGNOSIS – Check all that apply
(If available attach Psychological Evaluation) Please refer to evaluations for formal diagnosis:

IQ:
- ☐ Mild (52-70)
- ☐ Moderate (36-51)
- ☐ Severe (20-35)
- ☐ Profound (20 or below)
- ☐ Borderline (71-85)

- ☐ Down Syndrome
- ☐ Cerebral Palsy
- ☐ Epilepsy/Seizure Disorder
- ☐ Autism
- ☐ Aspergers Disorder
- ☐ Fetal Alcohol spectrum Disorder
- ☐ Traumatic Brain Injury (prior to age 22)
- ☐ Cognitive Disability
- ☐ Other:_____
- ☐ Other:_____

FINANCIAL INFORMATION – Check all that apply
To assist in determining applicant's eligibility for services, please list sources and amounts of income:

- ☐ Medicare Number _____
- ☐ Medicaid Number _____
- ☐ Social Security Number _____ Amount _____ Payee:_____
- ☐ Supplemental Security Income Amount _____ Payee:_____
- ☐ Social Security Disability Insurance Amount _____ Payee:_____
- ☐ Veteran's Administration Amount _____ Payee:_____

Other sources of Income and Amount: (e.g.: joint bank accounts, Indian Land Lease, trusts, stocks, bonds, CDs, wages, interest, property owned, etc.) _____

COMMUNICATION – Check primary means of applicant's expression

☐ Speaks ☐ Sign Language ☐ Gestures ☐ Communication Device
☐ Other (please specify): _____

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ADAPTIVE EQUIPMENT – Check all of the adaptive devices or equipment the applicant uses:

- ☐ Needs Assistance Walking
- ☐ Hearing Aid
- ☐ Catheter
- ☐ G-Tube
- ☐ J-Tube
- ☐ Corrective Lenses
- ☐ Colostomy Bag
- ☐ Wears Helmet
- ☐ White Cane
- ☐ Needs Assistance on Stairs
- ☐ Orthopedic Splints
- ☐ Orthopedic Shoes/Braces
- ☐ Walker
- ☐ Gait Belt
- ☐ Manual Wheelchair
- ☐ Electric Wheelchair
- ☐ Mechanical Lift
- ☐ Other: _____

MEDICAL INFORMATION and RELATED SERVICES – Check all that apply. If applicable, attach extra page(s)

- ☐ Speech/Language
- ☐ Physical Therapy
- ☐ Occupational Therapy
- ☐ Counseling
- ☐ Psychiatric
- ☐ Medical Diagnosis: _____
- ☐ Medications: 1. Name: _____ Reason: _____
  2. Name: _____ Reason: _____
  3. Name: _____ Reason: _____

Previous/Current Placements and dates-

_____

_____

_____

_____

_____

_____

_____

_____

Required documents to enclose with this application – Check and attach all that apply

- ☐ IEP (if applicable) (Multidisciplinary Team Assessment)
- ☐ Support Plan
- ☐ Diagnosis Documentation (Psychological Evaluation and Medical Information)

SUPPORTS I NEED TO KEEP MYSELF & OTHERS SAFE – Check all that apply. (if applicable, attach extra page(s).

☐ Intentionally hurts self

Please describe: _____

What appears to cause this? _____

What is frequency? _____

☐ Physically aggressive towards others

Please describe: _____

What appears to cause this? _____

What is frequency? _____

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Is this potentially dangerous to others? _____

If yes, explain: _____

☐ Disruptive (such as frequent tantrums, screaming, other emotional outbursts)

Please describe: _____

What appears to cause this? _____

What is frequency? _____

☐ Sexual concerns

Please describe: _____

What appears to cause this? _____

What is frequency? _____

☐ Takes others possessions

Please describe: _____

What appears to cause this? _____

What is frequency? _____

☐ Any other concerns such as verbal or physical threats, difficulty relating to peers/authority, safety supports, etc.

Please describe: _____

What appears to cause this? _____

What is frequency? _____

Legal convictions/history ☐ No ☐ Yes

If yes, please describe: _____

I acknowledge this is a request for agency planning purposes. Completion of this form is not a guarantee of services nor is it a commitment on my part to accept offered services.

APPLICANT SIGNATURE: _____

PARENT/LEGAL REPRESENTATIVE SIGNATURE: _____

DATE: _____

What do others like and admire about me:

Things I like to do and things I am good at:

Things that are important to me and make me happy:

Supports I need-what I am looking for to be successful:

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Home & Community Based Service Providers (CSPs, FS 360)
Checklist

Name: _____

INFORMATION REQUIRED FROM PARENTS:
Date Submitted:

_____ Completed Request for Services
_____ Completed Agency Application
_____ Authorization for Release of Information (current with in 12 months)
_____ Copy of Guardianship Order (if applicable)
_____ Copy of Certified Birth Certificate
_____ Copy of Social Security Card
_____ Copy of State-Issued Photo ID Card
_____ Copy of Medicaid/Medicare Card(s)
_____ Copy of Medicare D Card (if applicable)

INFORMATION REQUIRED FROM SCHOOL DISTRICT:
Date Submitted:

_____ Psychological Evaluation (**Wechsler Adult Intelligence** Test preferred)
_____ Current ICAP and Summary Printout (with in 12 months of enrollment)
_____ Most Recent 3-year Multidisciplinary Evaluation (if testing is included)
_____ Updated Medical/Social Assessment
_____ Current IEP

INFORMATION REQUIRED FROM PRIMARY PHYSICIAN:
Date Submitted:

_____ "Home Community-Based Services (Medicaid)
_____ Physical Examination (dated within 12 months of application)
_____ List of prescription medications signed by primary physician
_____ Current Vaccination Record
_____ TB Risk Assessment (dated within 12 months of application)

ADDITIONAL RECOMMENDATIONS:

_____ Tour of agency
_____ Tour of available residential services (when applicable)
_____ Meet with provider
_____ Complete one page profile