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

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 or 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*
    2. *communication*
    3. *mobility*
    4. *learning*
    5. *self-direction*
    6. *capacity for independent living*
    7. *economic self-sufficiency;*
- *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
6 Harrington Road - Simpson Hall
Cranston, RI 02920
(401) 462-3421

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 **Private Insurance Card** *(if applicable)*

☐ Copy of **Medicaid and/or Medicare Card** (Medicaid/Medicare is not necessary for application submission)

☐ 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

☐ **SASID #**: Obtained through your school primary teacher

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

For Internal Use Only

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#:** _____

SASID # (please obtain from primary teacher): _____

Should school contact also receive application updates? ☐ Yes ☐ No

If yes, email address: _____

Other Services

Are you receiving services from:
(check all that apply)

☐ CEDAR ☐ ORS
☐ HBTS ☐ DCYF
☐ PASS

BHDDH

Please indicate how you learned about the Division of Developmental Disabilities/BHDDH:

_____

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, to include medical, behavioral, and developmental, 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: 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 3**

☐ **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

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

C. SELF CARE

dressing, eating, grooming, hygiene

Do you need help to do the following:

Activity	None	Prompting	Direct
Bathing:	☐	☐	☐
Tooth brushing:	☐	☐	☐
Hair washing:	☐	☐	☐
Toileting:	☐	☐	☐
Dressing:	☐	☐	☐
Eating:	☐	☐	☐

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 or physical support 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

Additional Comments:

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? ☐ Yes ☐ No
(phone them or otherwise contact to make plans to get together)

Do you need help to get out of your home in case of emergency? ☐ Yes ☐ No
If yes, please describe:

How long are you comfortable being home alone?

List two reasons to call 911:

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:

Activity	None	Prompting	Direct
Stove:	☐	☐	☐
Microwave:	☐	☐	☐
Dishwasher:	☐	☐	☐
Hand Wash Dishes:	☐	☐	☐

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:

Activity	None	Prompting	Direct
Vacuuming:	☐	☐	☐
Laundry:	☐	☐	☐
Changing Bedding:	☐	☐	☐
Sweeping and Mopping:	☐	☐	☐
Cleaning a Bathroom:	☐	☐	☐

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:

Activity	None	Prompting	Direct
Riding the RIPTA Bus:	☐	☐	☐
Shopping (Food, Clothes):	☐	☐	☐
Setting Appointments:	☐	☐	☐
Getting to Appointments:	☐	☐	☐
Following Doctor's Orders:	☐	☐	☐
Taking Medication:	☐	☐	☐

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:

Activity	None	Prompting	Direct
Locate a job & complete application:	☐	☐	☐
Participate in basic job interview:	☐	☐	☐
Learn the job:	☐	☐	☐
Return from break on time:	☐	☐	☐
Accept correction:	☐	☐	☐
Working with others:	☐	☐	☐

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 3: 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 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.

Name	Relationship to applicant (*e.g., guardian, representative*)		
Address	**City**	**State**	**ZIP**

SECTION 5: DEMOGRAPHICS AND OTHER INFORMATION

Demographic Information

Racial/Ethnic Heritage: ☐ White (non-Hispanic) ☐ Black (non-Hispanic) ☐ Hispanic
☐ Asian/Pacific Islander ☐ American Indian/Alaskan Native ☐ Other

Marital Status: ☐ Never Married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

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)*? ☐ Yes ☐ No Type/Language:

Please indicate the primary language of your parent/guardian:

Do you require an adaptive communication device?: ☐ Yes ☐ No Specify:

Medical Insurance

Do you have Medicaid? ☐ Yes ☐ No Do you have Medicare? ☐ Yes ☐ No

If yes, Medicaid # *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
6 Harrington Road - Simpson Hall
Cranston, RI 02920
(401) 462-3421

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.

Signature		Date	
Print name			

Relationship

- ☐ Self (*adult applicant*)
- ☐ Adult's court-appointed guardian
- ☐ Minor's custodial parent or legal guardian