STATE OF RHODE ISLAND
Department of Behavioral Healthcare, Developmental Disabilities and Hospitals
DIVISION OF DEVELOPMENTAL DISABILITIES
6 Harrington Road
Cranston, RI 02920-3080
TEL: (401) 462-3421
FAX: (401) 462-2775

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 2 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.

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

Complete application packets with all required documents (see Checklist on page 2), 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. An in-person interview may be requested.

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.

Questions

If you have any questions while completing these forms, please call the Call the Division of Developmental Disabilities (DDD) Eligibility Supervisor at 401-462-2209.

Disability Related Documentation

- ☐ **Official Diagnosis** of a developmental disability by a medical doctor, psychologist, or licensed clinician (such as Down Syndrome, Fragile X Syndrome, or Intellectual Disability)
- ☐ **Intelligence Quota (I.Q.) / Cognitive Tests** (Completed between ages 14-22)
- ☐ **Medical History** only related to a disability (including PT/OT records)
- ☐ **Psychiatric Records** including any psychiatric hospitalizations.
- ☐ **Assessments** from current or previous service providers (HBTS/PASS/Home Health)

General Documentation

- ☐ Copy of **Birth Certificate or I-94 Form**
- ☐ Copy of **Social Security Card**
- ☐ Copy of **Legal Guardianship**, **Power of Attorney or Supported Decision Making Agreement** if applicable

All applicants must meet both clinical and financial eligibility for Medicaid long-term services and supports.

A) Clinical Eligibility for DD Services:

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. *Learning*
  2. *Self-care*
  3. *Expressive/Receptive Language*
  4. *Mobility*
  5. *Self-direction*
  6. *Capacity for independent living*
  7. *Economic self-sufficiency*
- *reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment or other services which are life-long of extended duration and are individually planned and coordinated.*

B) Financial Eligibility

Applicants must also meet financial eligibility for Medicaid long term services and supports. Following determination of clinical eligibility, an assigned social caseworker can assist you with this process.

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Application For Services

For Internal Use Only

Section 1: Personal Information

Applicant Name: **Gender:**

Applicant email: **Date of Birth:**

Residence Address:

Street:

Apt:

City, State Zip:

Telephone:

Mailing Address (if different):

Street/PO Box:

Apt:

City, State Zip:

Living Arrangements: ☐ Alone ☐ With Family ☐ Group Home/Residential ☐ Other

Legal Guardian

If you are 18 years of age or older when submitting this application, do you have:

Legal Guardian ☐ Yes ☐ No
Power of Attorney ☐ Yes ☐ No
Supported Decision Making Agreement in place? ☐ Yes ☐ No

If YES, please provide name(s) and contact details here:

Name: Phone:
Address: Email address:
Relationship:

Name: Phone:
Address: Email address:
Relationship:

Preferred Communication Format

I prefer written communication ☐ Mail ☐ Email

What language do you prefer? _____

Do you need an interpreter (including sign language)? ☐ Yes ☐ No

Please indicate the primary language of your parent/guardian/representative _____

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

Check if you are or have been involved with the following agencies:

Office of Rehabilitation Services (ORS)	☐ Yes	☐ No	☐ Not Sure
Department of Children Youth & Families (DCYF)	☐ Yes	☐ No	☐ Not Sure
HBTS/PASS	☐ Yes	☐ No	☐ Not Sure
Home Health	☐ Yes	☐ No	☐ Not Sure

School Information

Has Applicant left all school funded services? ☐ Yes ☐ No

Is Applicant currently attending school, including a transition program? ☐ Yes ☐ No

If YES, Anticipated date of ending school funded services: _____

Name of School: _____

School Contact Person: _____ Phone#: _____

Email address: _____

Have you ever had an: ☐ IEP or ☐ 504 Plan?

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

Section 2: Functional Information

A. LEARNING

Do you have any sensory issues that significantly interfere with your daily functioning? Sensory issues include over reactions or under reactions to light, noise, smell, taste, or texture that interfere with everyday life. ☐ Yes ☐ No

If YES, please describe how this impacts your daily life.

Do you have any issues with executive functioning that significantly interferes with daily functioning? Executive functioning includes adaptability, self-control, planning, organization, and using learned information. ☐ Yes ☐ No

If YES, please describe how this impacts your daily life:

B. SELF-CARE

NONE = No assistance needed, independent with task
PROMPTING = Verbal or gestural reminders to initiate or for thoroughness
DIRECT = Physical assistance or total support needed (hand over hand or step by step directions

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:

C. EXPRESSIVE/RECEPTIVE LANGUAGE

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? ☐ Yes ☐ No

(For example, sign language, communication device, pictures, or does someone you know "interpret" what you mean).

If YES, please describe:

D. MOBILITY

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

Additional comments:

E. SELF-DIRECTION

Do you receive SSI? ☐ Yes ☐ No

If YES, do you have a representative payee? ☐ Yes ☐ No

Do you pay any bills on your own? ☐ Yes ☐ No

What do you like to do with your free time? Please describe below:

Are you able to keep in touch with friends on your own? ☐ Yes ☐ No

Do you need help to get out of your house in case of emergency? ☐ Yes ☐ No

If yes, please explain

How long are you comfortable being home alone?

Do others take advantage of you (borrow money and not pay you back or take your belongings?

☐ Yes ☐ No

If YES, please explain:

F. INDEPENDENT LIVING

NONE = No assistance needed, independent with task
PROMPTING = Verbal or gestural reminders to initiate or for thoroughness
DIRECT = Physical assistance or total support needed (hand over hand or step by step directions

1. **Meal preparation:**
   How much support is needed to complete the following:

Activity	None	Prompting	Direct	Never tried
Prepare a cold meal:	☐	☐	☐	☐
Use a microwave or toaster:	☐	☐	☐	☐
Prepare a simple meal (ex. pasta):	☐	☐	☐	☐
Prepare a full meal (ex. Chicken dinner):	☐	☐	☐	☐
Make a grocery list:	☐	☐	☐	☐
Read and follow a recipe	☐	☐	☐	☐

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

2. Household Chores:

NONE = No assistance needed, independent with task
PROMPTING = Verbal or gestural reminders to initiate or for thoroughness
DIRECT = Physical assistance or total support needed (hand over hand or step by step directions

How much support is needed to complete the following chores:

Activity	None	Prompting	Direct	Never tried
Vacuuming:	☐	☐	☐	☐
Laundry:	☐	☐	☐	☐
Changing Bedding:	☐	☐	☐	☐
Sweeping and Mopping:	☐	☐	☐	☐
Cleaning a Bathroom:	☐	☐	☐	☐
Wash dishes/load &unload dishwasher	☐	☐	☐	☐

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

3. Life Skills

Do you have a driver's license?	☐ Yes	☐ No
Are you able to use public transportation/Ride share service?	☐ Yes	☐ No
Do you carry money or a debit card?	☐ Yes	☐ No
Can you tell someone when you are sick?	☐ Yes	☐ No
Do you know how to reach out to an emergency contact?	☐ Yes	☐ No
Can you make a single item purchase on your own at a store or online?	☐ Yes	☐ No
Can you make multiple item purchases on your own at a store or online?	☐ Yes	☐ No
Are you able to set and get to an appointment on your own?	☐ Yes	☐ No

Do you take medication on your own?	☐ Yes	☐ No	☐not applicable
Do you refill medication on your own?	☐ Yes	☐ No	☐not applicable

If NO, please explain:

G. ECONOMIC SELF-SUFFICIENCY

NONE = No assistance needed, independent with task
PROMPTING = Verbal or gestural reminders to initiate or for thoroughness
DIRECT = Physical assistance or total support needed (hand over hand or step by step directions

Activity	None	Prompting	Direct	Never tried
Complete application	☐	☐	☐	☐
Participate in basic job interview	☐	☐	☐	☐
Follow instructions on the job	☐	☐	☐	☐
Return from break on time	☐	☐	☐	☐
Accept feedback	☐	☐	☐	☐
Work well with others	☐	☐	☐	☐

Additional comments:

List any paid jobs you have held or currently hold:

List volunteer jobs you have held or currently hold:

SECTION 3: **OPTIONAL**

Services requested through the Division of Developmental Disabilities

Describe the type of services or supports you are looking for.

Section 4: Notification

Notification Of Eligibility Decision			
If you would like a copy of the clinical 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
Email:			

SECTION 5: 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.

SIGNATURE of Applicant or Legal Guardian:

PRINT NAME of Applicant or Legal Guardian:

Rhode Island Department of Behavioral Healthcare, Developmental Disabilities & Hospitals Privacy Notice

Information shared will be protected by compliance with all relevant federal and state laws and regulations protecting your privacy, including but not limited to the Health Insurance Portability and Accounting Act of 1996.