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)

South Dakota Division of Developmental Disabilities
Application for Services

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

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

IQ: ☐ Mild (52-70) ☐ Down Syndrome ☐ Fetal Alcohol spectrum Disorder
☐ Moderate (36-51) ☐ Cerebral Palsy ☐ Traumatic Brain Injury (prior to age 22)
☐ Severe (20-35) ☐ Epilepsy/Seizure Disorder ☐ Cognitive Disability
☐ Profound (20 or below) ☐ Autism ☐ Other:______________________
☐ Borderline (71-85) ☐ Aspergers Disorder ☐ 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): ____

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

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

PORTS 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?

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:

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

Community Support Providers

Ability Building Services (ABS)
909 West 23rd
Yankton, SD 57078-1510
Telephone: (605) 665-2518 / FAX: (605) 665-0206
Web Site: http://www.abilitybuildingservices.com
Executive Director: Beth Kathol

ASPIRE (ASP)
607 North Fourth Street
Aberdeen, SD 57401-2733
Telephone: (605) 229-0263 / FAX: (605) 225-3455
Web Site: http://www.aspiresd.org
Executive Director: Jennifer Gray

ADVANCE (ADV)
301 Division Ave.
Brookings, SD 57006-0810
Telephone: (605) 692-7852 / FAX: (605) 692-6169
Web Site: http://www.advancebkg.info
President/CEO: Brian Ardry

Black Hills Special Services Cooperative (BHSSC)
2885 Dickson Dr.
PO Box 218
Sturgis, SD 57785-0218
Telephone: (605) 347-4467 / FAX: (605) 347-5223
Web Site: http://www.bhssc.org
Executive Director: Joe Hauge; DD Director: Shirley Halverson

Black Hills Special Services Cooperative - Hot Springs
737 University Avenue
Hot Springs, SD 57747
Telephone: (605) 745-3408 / FAX: (605) 745-4474
Executive Director: Joe Hauge; DD Director: Shirley Halverson

Black Hills Works (BHW)
3650 Range Road
PO Box 2104
Rapid City, SD 57709-2104
Telephone: (605) 343-4550 / FAX: 343-0879
Web Site: http://www.bhws.com
CEO: Brad Saathoff

Community Connections, Inc. (CCI)
445 W 3rd St.
PO Box 742
Winner, SD 57580-0742
Telephone: (605) 842-1708 / FAX: (605) 842-0309
Executive Director: Melony Bertram

DakotAbilities (DA)
1116 S. 4th
Sioux Falls, SD 57105-6494
Telephone: (605) 334-4220 / FAX: (605) 334-7976
Web Site: http://www.dakotabilities.org
Executive Director: Robert Bohm

Dakota Milestones (DM)
117 E Beebe Ave
PO Box 248
Chamberlain, SD 57325-0248
Telephone: (605) 734-5542 / FAX: (605) 734-4260
Web Site: http://www.dakotamilestones.org
Executive Director: Ronda Schelske

Huron Area Center for Independence (HACFI)
258 3rd Street SW
Huron, SD 57350
Telephone: (605) 352-5698 / FAX: (605) 352-1013
Web Site: http://www.cfindependence.com
Executive Director: Randy Meendering

LifeQuest (LQ)
804 North Mentzer
Mitchell, SD 57301-2198
Telephone: (605) 996-2032 / FAX: (605) 996-0972
Web Site: http://www.lifequestsd.com
Executive Director: Pam Hanna

LifeScape (LS)
2501 W 26th Street
Sioux Falls, SD 57105
Telephone: (605) 444-9500 / FAX: (605) 444-9501
Web Site: http://www.LifeScapeSD.org
President/CEO: Anne Rieck McFarland

LIVE Center, Inc. (LIVE)
407 2nd Ave. W
PO Box 59
Lemmon, SD 57638-0059
Telephone: (605) 374-3742 / FAX: (605) 374-3238
Executive Director: Julie Peterson

New Horizons (NH)
c/o Human Services Agency
123 19th Street NE
PO Box 1030
Watertown, SD 57201-6030
Telephone: (605) 886-0123 / FAX: (605) 886-5447
Web Site: http://www.humanserviceagency.org
HSA President/CEO: Dr. Charles L. Sherman; NH Executive Director: Jodie Marotz

Northern Hills Training Center (NHTC)
625 Harvard Street
Spearfish, SD 57783-9730
Telephone: (605) 642-2785 / FAX: (605) 642-5069
Web Site: http://www.nhtc.org
Executive Director: Rich Mulholland

OAHE, Inc. (OAHE)
125 W Pleasant Dr. Suite #1
PO Box 503
Pierre, SD 57501-0503
Telephone: (605) 224-4501 / FAX: (605) 224-9619
Web Site: http://www.oaheinc.com
Executive Director: Ann Hoye

Resources for Human Development (RHD)
705 E 41st Street Suite 230
Sioux Falls, SD 57105
Telephone: (605) 377-6490 / FAX: (605) 377-6015
Web Site: https://www.rhd.org/program/host-family-home-program/
Director: Kelli Anderson

Southeastern Directions for Life (SE)
2000 South Summit
Sioux Falls, SD 57105
Telephone: (605) 336-0510 / FAX: (605) 338-9385
Web Site: http://www.southeasternbh.org
Executive Director: Clark Guhin

SESDAC, Inc. (SESDAC)
1314 East Cherry
Vermillion, SD 57069-1606
Telephone: (605) 624-4419 / FAX: (605) 624-7375
Web Site: http://www.sesdac.org
Executive Director: Gerry Tracy

Valiant Living
706 SW 7th St
PO Box 450
Madison, SD 57042-0450
Telephone: (605) 256-6628 / FAX: (605) 256-2060
Web Site: http://www.eccoinc.org
Executive Director: Vicki Kommes

Volunteers of America/West Oak (VOA)
3520 S Gateway Lane
Sioux Falls, SD 57106
Telephone (VOA): (605) 334-1414 / FAX: (605) 335-3121
Telephone (WO): (605) 367-4293 / FAX: (605) 367-5714
President/CEO: Dennis Hoffman; West Oak Managing Director: Brian Mulder

South Dakota Department of Human Services

Division of Developmental Disabilities
Hillsview Properties Plaza
East Highway 34, c/o 500 East Capitol
Pierre, SD 57501
Telephone: (605) 773-3438

South Dakota Developmental Center
17267 W 3rd Street
Redfield, SD 57469
Telephone: (605) 472-2400