

**South Dakota Department of Human Services
Division of Developmental Disabilities Application for Services**

Applicant Name:

Date of Birth:

Sex:

Current Address:

Mailing Address (if different from current address):

Phone number:

Email Address:

Preferred method of contact:

Preferred person to contact if not the applicant:

Phone number:

Email Address:

First time applying? Yes No Unknown

Currently receiving Medicaid? Yes No **Currently receiving SSI/SSDI?** Yes No

Diagnosis: Intellectual/Cognitive Disability Autism Down Syndrome
 Cerebral Palsy Other:

What are your strengths? What do people like about you?

What things do you like to do? How do you like to spend your day?

Why are you applying for services from DDD?

What supports do you need to be successful?

What is your primary way to communicate?

Written language?

What language do you best speak/or understand?

Do you need an interpreter/translator? Yes No

Daily Life and Employment

Education:

Are you currently in school? Yes No

If yes, which school:

School contact:

Are you on an IEP or 504 plan? Yes No

Do you have a signed diploma or a certificate of completion? Yes No

Do you have a GED? Yes No

Employment/Volunteering:

Are you currently working or volunteering? Yes No

If yes, where?

If no, are you interested in working? Yes No

Are you working in Vocational Rehabilitation? Yes No

Community Living

Do you currently live: On your own With Family With Roommates

How much time do you typically spend alone each day?

Are you interested in receiving residential supports? Yes No

If yes: Round-the-clock services Daily residential supports Residential supports as needed

Safety and Security

Legal Representative/Conservatorship – Check all that apply to the applicant if over 18 years old.

No Legal Representative in place.

Court Ordered Legal Representative and type (medical, limited, etc.): _____

Court Ordered Conservator and Name if different from Legal Representative: _____

Power of Attorney and Type: _____

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

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

Email Address: _____

Please attach copies of the Legal Documents

Are you currently incarcerated? Yes No

Have you ever been involved with the police? Yes No

If yes, have any of these issues resulted in a misdemeanor or felony charges? Yes No

Healthy Living

Do you use adaptive medical equipment? Yes No

If yes, please select below

Walking assistance (cane, walker, crutches) Wheelchair Adaptive bike or stroller

Standing devices Mechanical Lifts Orthotics Specialized bed

Adaptive eating equipment Other: _____

Are you currently taking any medications? Yes No

If yes, please attach a medication list.

Understanding your behavioral health needs allows us to ensure that the most appropriate services and supports are in place for you to be successful. Please describe this information to the best of your ability. Your application will still be considered by DDD if this section is not completed.

What is the behavior?	Describe the behavior	How often does it happen?	What supports help me be successful?
<input type="checkbox"/> Aggression towards others			
<input type="checkbox"/> Intentionally hurts self			
<input type="checkbox"/> Disruptive			

<input type="checkbox"/> Sexual Concerns			
<input type="checkbox"/> Running away			
<input type="checkbox"/> Damaging property			
<input type="checkbox"/> Other			

I would like you to contact me/my representative to discuss these behaviors in more detail:

Yes No

What is currently working well in your life?	What is not working? What is needed to improve?

Have you ever received services from DDD? Yes No

If yes, when and what services did you receive:

Which DD waiver or program are you interested in receiving services from?

- Family Support 360
 CHOICES
 Strengthening Family
 Respite Care
 Community Training Services

What services or supports do you feel like you need to successful? *Please reference the service descriptions outlined on pages 12 and 13 of the Application Guide for DD Services:*

I understand that for an individual to be eligible for Family Support 360 or CHOICES he/she must have a qualifying diagnosed developmental or intellectual disability.

SIGNATURE _____ DATE _____



CHOICES Supplemental Information

If you are seeking services from the CHOICES waiver. Please include the following documentation (as applicable) attached with your application:

- Medical history documentation
- List of physicians/last examinations (please include dental and eye doctor examinations)
- Immunization history
- Documentation of any allergies
- Additional behavior support information
- Relevant legal history documentation
- Nutritional information (i.e., specialized diet, swallow studies)