

INSTRUCTIONS FOR COMPLETING:

The **APPLICATION FOR SERVICES FROM THE AGENCY FOR PERSONS WITH DISABILITIES**

AND

The **APPLICATION FOR WAIVER PARTICIPATION**

To submit an application to become a client of the Agency for Persons with Disabilities, please print out and complete the following forms:

Application for Services from the Agency for Persons with Disabilities

If waiver services are requested, please also complete the:

Application for Waiver Participation

Instructions for each are attached. Please either type the information, or print neatly. Please do not complete the areas in gray designated “for completion by APD office staff only”. When complete, go to

<http://apd.myflorida.com/about/contact.htm>

to obtain the address for the area office to which you should submit the application. Please submit both applications concurrently.

Grey areas are for completion by APD office staff only.

<p>1. AREA OFFICE: _____</p> <p>Date of Application: ___/___/___</p> <p>Name of APD Staff Person: _____</p> <p>Phone #: _____</p>	<p>2. Reason for Application/Type of Assistance Requested:</p>
<p>3. Person for Whom Support and Services Are Requested</p> <p>Name: _____ (Last) (first) (MI) (Suffix)</p> <p>SS#: _____</p> <p>Address: _____</p> <p>_____</p> <p>Phone #: _____</p> <p>Email: _____</p> <p>DOB: _____ Sex _____</p> <p>Legal Status: _____ (minor, adult, or adult adjudicated incompetent)</p>	<p>4. Person Assisting Applicant</p> <p>Name: _____ (Last) (first) (MI)</p> <p>Relationship to Applicant: _____</p> <p>Address: _____</p> <p>_____</p> <p>Phone #: _____</p> <p>Email: _____</p>
<p>5. ELIGIBILITY DETERMINATION</p> <p>Eligible: <input type="checkbox"/> Yes <input type="checkbox"/> No Date determined: ___/___/___</p> <p>Eligibility Category _____</p> <p>Ineligible Date: ___/___/___</p> <p>Reason: _____</p>	<p>6. Residency: To receive services from the Agency for Persons with Disabilities the applicant must live in Florida. Please indicate that the person applying for services resides in Florida. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>County of Residence: _____</p> <p>Type of documentation provided (voter registration, driver's license, bill with address on it, etc.):</p>
<p>7. Collateral/Supporting Information or Source of Information About Disability (IQ scores, medical records, school records, etc.)</p>	<p>8. Assessments for Eligibility</p> <p>_____ (Signature of applicant or legal guardian)</p> <p>I agree to participate in assessment(s) listed on this form that are needed to find out if I am eligible for services provided by the Agency for Persons with Disabilities. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Assessments Needed: _____</p>

INSTRUCTIONS

GREY AREAS ON FORM ARE TO BE COMPLETED ONLY BY APD STAFF OR IN THE PRESENCE OF APD STAFF.

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1. **Agency for Persons with Disabilities Area:** Enter the number of the APD Area in which the person is applying for services.

Date: Enter the date the application form is being completed.

Name of APD staff person: Enter the name of the Agency for Persons with Disabilities staff person recording the application information.

Phone #: Enter the phone number of the Agency for Persons with Disabilities staff person recording the application information.

Eligibility Determination: *(This is the determination of eligibility or ineligibility for Agency for Persons with Disabilities.)*

Eligible:___Date:___: Check () if the person is determined eligible for Agency for Persons with Disabilities services and enter the date the determination is made.

Ineligible:___Date:___: Check () if the person is determined not eligible for Agency for Persons with Disabilities services and enter the date the determination is made.

Reason_____: Write down the reason the person is not eligible for services.

2. **Reason for Application/Type of Assistance Requested:** The services needed by the individual should be listed, such as respite, supported living, supported employment, personal care assistance, etc.

3. **Person for whom supports and services are requested:**

Name: Enter the legal name, including the last name, first name and middle initial, of the individual applying Agency for Persons with Disabilities services.

SS#: Enter the individual's Social Security number.

Address: Enter the individual's mailing address and, if different, the street address where the person lives.

Phone #: Enter the phone number(s) where the individual or the person assisting with the application can be reached during the day and/or evening.

Email: Enter the email address where the individual or the person assisting with the application can be reached during the day and/or evening.

DOB, Sex, Legal Status: Enter the person's date of birth, sex and legal status. (**Minor** – under 18, **Adult** – 18 and older, not adjudicated by court of law to be incompetent, **Legally Incompetent** – the individual has been adjudicated incompetent and a plenary guardian has been appointed.)

4. **Person Assisting Applicant:** (This section applies only for those persons who are assisting the individual in applying to Agency for Persons with Disabilities services, such as guardians, friends, and/or advocates.)

Name: Enter the legal name, including the last name, first name and middle initial, of the person who is assisting the individual who is applying to the Agency for Persons with Disabilities for services.

Relationship to Applicant: Identify the type of relationship the individual has with the applicant (i.e., friend, coworker, family, client advocate, guardian).

Address: Enter the individual's mailing address and, if different, the street address where the individual lives. If the individual has been adjudicated incompetent, the address of the legal guardian should be entered as the mailing address.

Phone #: Enter the phone number(s) where the person assisting can be reached during the day and/or evening.

Email: Enter the email address where the person assisting with the application can be reached during the day and/or evening.

5. **Eligibility Determination** This area to be completed by APD staff when final determination of eligibility has been completed.

6. **Residency:** Check (✓) either Yes or No as to whether the applicant is a resident of the State of Florida. The applicant should provide documentation of residency, if possible. Examples of documentation include voter's registration, a current bill with mailing address, driver's license, etc. Residency implies intent to make Florida the primary, rather than a temporary residence.

County of Residence: Enter the county where the person lives.

The APD worker will note the documentation that has been provided.

7. **Collateral/Supporting Information or Source of Information about Disability:** Enter the title(s) of any assessments, or instruments that have been used and are being submitted or will be submitted to provide documentation to determine eligibility for Agency for Persons with Disabilities services. Identify the titles of assessments/instruments that may be needed to determine eligibility. Indicate any other materials, collateral information or assessments/tests of eligibility Area staff will obtain and file all medical, clinical and educational information. An individual can be determined eligible based on information received via telephone or verbally with written copies obtained and filed at a later date.

8. **Assessments Needed:** If the collateral information submitted is insufficient for determination of eligibility, or if no collateral information is available, it may be necessary to conduct an assessment of intelligence or a functional assessment to determine eligibility. The applicant or legal guardian should sign to show consent.

If assessments are needed to determined eligibility, the APD staff will complete this field upon consultation with senior staff.

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9. **Name:** Enter the legal name, including the last name, first name and middle initial of the person applying Agency for Persons with Disabilities services.

SS#: Enter the individual's Social Security number.

10. **I have received a copy of the Bill of Rights of Persons who are Developmentally Disabled:** Check (✓) whether the individual receives a copy of the Bill of Rights at the time of application. (The Bill of Rights will be provided by mail or at the first face-to-face meeting and the opportunity to discuss them will be provided at that meeting.)

Rights: Check (✓) either Yes or No based as to whether the applicant and/or the person assisting the applicant seeking eligibility would like to have the Rights explained.

11. **Agreement to keep the Agency informed of any changes in address or telephone number.**
Please read carefully and provide an alternate contact, if possible.

12. **Signature of Individual and/or Guardian:** The individual applying to the Agency for Persons with Disabilities must sign here, regardless of legal status, unless physically unable to sign or a minor. An "X" or other mark, identified as "his/her mark" is acceptable, with a witness signing as such. If the individual is not legally competent, the guardian may sign.

Date: Enter the date the individual applying for the Agency for Persons with Disabilities signs the application.

Signature of Person Assisting the Individual, if applicable: The person assisting the individual applying to the Agency for Persons with Disabilities should sign here. If the individual is legally incompetent or a minor the parent or guardian must sign here.

Date: Enter the date the person assisting the individual applying for the Agency for Persons with Disabilities signs the application.

13. Received in Area Office: The area office shall date-stamp the Application on the day of receipt.

14. Referral: *(This section is to be used to document referrals for supports and services made to places or people other than the Agency for Persons with Disabilities.)*

From – Date: Enter the name of the agency and/or program in which the individual is presently involved and the date the referral from that program was received. If appropriate, enter the name and contact information for the individual making the referral.

To – Date: Enter the name of the agency and/or program from which the applicant is seeking additional supports or services and indicate the date of referral to that program, as well as a contact person and/or the address and telephone number.

A photocopy of Page 2 listing all referrals and the individual's rights and responsibilities shall be given to the applicant or guardian at the first face-to-face meeting.

Agency for Persons with Disabilities
Home and Community-Based Services Waiver
Application for Participation

For myself or on behalf of the individual named below, I am requesting participation in the DD/HCBS waiver program. This individual is or is not a current recipient of Developmental Disabilities.

Applicant Name: _____

Date of Birth: _____ SSN: _____ Medicaid yes #: _____
 (Medicaid #, if known)

Street Address: _____

 City State Zip

Parent/Guardian: _____
 Street Address: _____

 City State Zip

Phone Number: (home) _____ (work) _____
 (self/parent/guardian phone 1)
 Phone Number: (home) _____ (work) _____
 (self/parent/guardian phone 2)

I believe the services or supports identified below are required by the person named above to allow them to remain in the community and avoid the need for institutional placement.

My signature below indicates that I have received the following pamphlets explaining the Developmental Disabilities Home and Community-Based Services Waiver.

- DD/HCBS Waiver Eligibility (CI/PI 160-35, 7/2000)
- Due Process Rights (CI/PI 160-32, 4/2002)
- Medicaid Funded Services (CI/PI 160-36, 8/2000)
- DD/HCBS Waiver Services (CI/PI 160-34, 6/2000)

The information included on this application is true and accurate to the best of my knowledge.

Signature of Requestor _____ **Date of Request** _____

Date stamp date received by District _____ Return application to: _____

April 1, 2006

INSTRUCTIONS: Home and Community-Based Services Waiver Application for Participation

(Please complete online and print out or print out and complete all areas legibly.) *revise*

Applicant Name: Enter legal first name, middle initial and last name. Suffixes such as Jr., III, may be used.

Date of Birth: Enter month, day and year

SSN: Enter social security number. Please verify that is the SSN for the applicant and that it is correct.

Medicaid: If the applicant is already a Medicaid recipient, make a checkmark between “Medicaid” and “yes”. If known, enter the Medicaid number at #: (Note: The number on the gold card is not a Medicaid number.

Street Address: Enter the street address, City, State and Zip Code where the individual actually resides.

Parent/Guardian: Enter the first name, middle initial and last name of the legal guardian of a minor child or an individual who has been adjudicated incompetent, or a parent who is the primary caregiver of a legally competent adult if that individual needs assistance in managing their affairs.

Street Address: Enter the street address, City, State and Zip Code where the individual or parent/guardian receives their mail.

Phone Number (phone 1): Enter the cell/home number and the work number, if applicable, of the individual or the primary person to contact.

Phone Number (phone 1): Enter the cell/home number and the work number, if applicable, of the alternate contact.

Services or Supports: List the services or supports needed to keep the individual in the community (ex: behavior analysis, environmental accessibility adaptations, respite care, diapers, therapies, etc.)

Pamphlets: If the application is submitted by mail, the pamphlets will be mailed to the applicant upon receipt of the application. Signature is still required.

Signature of Requestor: The individual applying for waiver participation should must sign here, regardless of legal status, unless physically unable to sign or a minor. An “X” or other mark, identified as “his/her mark” is acceptable, with a witness signing as such. If the individual is not legally competent, the guardian may sign.

Date Stamp and Return Application to: For area office use only