



Application or Referral for Developmental Disability Services

Initial Application: _____ County: _____
 Referrals to: _____

Office Use Only (mm/dd/yy)	
Date received by provider	_____
Date received by county:	_____

Do you need help filling out this form? Yes No Alternate format Interpreter
 Format type: Audio Tape Braille CD Large Print Oral Presentation
 What language? _____ Sign Language

Applicant Information

Last Name: (please print)		First Name		Middle Initial	
Address	Street	City		State	Zip Code
Mailing Address (if different)			City	State	Zip Code
Birth Name				Social Security Number	
Date of Birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Birth Place		Phone ()	
Marital Status		Maiden Name (or other names used)			

Parent Information

Name of Parent: (Required if under 18)			
Current Address		City	State Zip Code
Mailing Address (if different)		City	State Zip Code

Legal Guardian/Conservator/Custodian

Does applicant have a court appointed: (check all that apply)

Legal Guardian Conservator Custodian

Note: Court order must be attached.

Name of Legal Guardian/Conservator/Custodian:			Phone
Location of Court			Date of Court Order
Current Address		City	State Zip Code
Mailing Address: (if different)			State Zip Code

Applicant Personal Information (Applicant Ethnic Origin)

Race (Check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Asian | <input type="checkbox"/> Native Hawaiian or Other Pacific Islander |
| <input type="checkbox"/> American Indian or Alaskan Native | <input type="checkbox"/> Unable to Determine |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> Multi-Racial (Specify): _____ |
| <input type="checkbox"/> White | |

Ethnicity

- | | |
|---|---|
| <input type="checkbox"/> Hispanic or Latino | <input type="checkbox"/> Nationality (Specify): _____ |
| <input type="checkbox"/> Not Hispanic or Latino | <input type="checkbox"/> Unable to Determine |

Language(s) Understood:

Languages(s) Spoken:

Religious Preference

- None Specify: _____

Personal Strengths: (capabilities, interests, hobbies, likes and dislikes)

Criminal History

Does applicant have criminal/juvenile court record? Yes No

State/County:	Offenses:
Services or conditions mandated by the court:	

Emergency Contacts

Name :	Relationship:	Phone: ()
		()
		()
		()

Next of Kin: (Name)	Relationship:	Phone: ()
Current Address:	City:	State: Zip Code:
Mailing Address: (if different)	City:	State: Zip Code:

Residential Placement History (examples; foster care, group care, nursing home, assisted living facility, institutional care, psychiatric hospital)

Use back of last page if more space is needed. Begin with most recent.

Address	Type of Living Situation	Dates

Educational History/Day Care (Begin with most recent e.g., early intervention, current day care, etc)

Most Recent	Dates Enrolled

Employment History (Begin with most recent. Include any adult current day services.)

Employer and Location:	Phone:()
Type of Work/Activity:	Dates:
Employer and Location:	Phone:()
Type of Work/Activity:	Dates:
Employer and Location:	Phone:()
Type of Work/Activity:	Dates:
Employer and Location:	Phone:()
Type of Work/Activity:	Dates:

Other Social Service Agencies

Agency Name:	Contact /Representative's Name:	Phone: ()	Dates:
		()	
		()	
		()	

Other Services Used

Briefly describe other services/special plans applicant is receiving: (e.g., in-home support, crisis services, vocational, medical, food benefits, mental health, child welfare, etc.)

Applicant's Financial Resources:

Please list current account balances and any trust or cash available. Include checking, savings or financial aid or loans applied for.

Type of Account	Establishment Name and Location	Balance
Checking		
Savings		
Burial Plan		
Trust		

Income Source	Monthly Amount	Date Applied (if not yet receiving)
Pay Check		
Food Benefits		
Social Security		
SSI		
Other:		
Other (e.g., railroad retirement, child support, veterans benefits, worker's compensation, unemployment, and public assistance):		
Represented Payee Name:		

Health Insurance (Complete those that apply.)

Coverage	Name Provider / Carrier (Medical, Dental, Mental Health)	Group No/ Policy #
Medicare		
Medicaid/Oregon Health Plan		
Veterans		
Private Insurance		
Other		

Disabilities (Complete all that apply)

Condition	Briefly Describe Current Function and Support
Cerebral Palsy	
Mental Retardation	

Disabilities (Continued): (Complete all that apply)

Condition	Briefly Describe Current Function and Support
Autism	
Down Syndrome	
Motor Issues	
Communication	
Vision Impaired	
Hearing Issues	
Mental/Emotional/ Behavioral	
Other Type of Disability	
Other Type of Disability	

Current Medications: (optional – may attach copy most recent Medication Administration Record (MAR) or physician’s orders)

Does applicant have any problems taking medications? Yes No

If “yes”, briefly describe: _____

Medication Name	Reason Taken	Physician	Phone
			()
			()
			()
			()
			()
			()

Medical References

Primary Care Physician Name:		Phone: ()	
Address:	City:	State:	Zip Code:

Dentist Name:		Phone: ()	
Address:	City:	State:	Zip Code:

Medical References (Continued)

Pharmacy:		Phone: ()	
Address:	City:	State:	Zip Code:

Preferred Hospital:	Phone: ()	City:
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Specialist Name:	Specialty:	Phone: ()	
Address:	City:	State:	Zip Code:

Specialist Name:	Specialty:	Phone: ()	
Address:	City:	State:	Zip Code:

Specialist Name:	Specialty:	Phone: ()	
Address:	City:	State:	Zip Code:

Specialist Name:	Specialty:	Phone: ()	
Address:	City:	State:	Zip Code:

Other issues you want us to know (i.e., serious allergies, behavior or medical issues, protective service needs, family/cultural issues, etc.).

Does applicant know this application is being submitted? Yes No

Signatures

Releases of information obtained? Yes No

Request and Consent to Receive Services
I hereby consent to receive services from Developmental Disabilities Services.
I understand I may discontinue services whenever I choose.

Receipt of Consumer Rights and Responsibilities
I acknowledge that I have been informed of my rights and responsibilities.

By signing below I agree that I have given true, correct and complete information.

Signature of person completing this application:	Relationship to Applicant:
Name (print):	Date:

Applicant's Signature (or legal guardian):	Date:
Name (print):	

Case Manager's Signature:
Name (print):

Release of Information (DHS 2099 or similar release) obtained? Yes No

Date of Application:	Referring Person:
Agency:	Phone: ()

Discrimination statement: *The Department of Human Services (DHS) will not discriminate against anyone. This means DHS will help all who qualify. DHS will not deny help to anyone based on age, race, color, national origin, sex, sexual orientation, religion, political beliefs or disability. You can file a complaint if you think DHS discriminated against you because of any of these reasons. To file a complaint, please read the "Client Discrimination Complaint Information" (DHS 9001) or call the U.S. Dept of Health & Human Services at 1-800-537-7697.*