



# Georgia Department of Behavioral Health and Developmental Disabilities

## Application for Intellectual/Developmental Disabilities Services

### Personal Details

All fields marked \* are required

First Name \*

M.I.

Last Name \*

Suffix (select one)

JR.  SR.  II  III

Maiden or Birth Surname

Preferred Name

Date of Birth (MMDDYYYY) \*

Gender (select one) \*

Male  Female  
 Transgender Male to Female  
 Transgender Female to Male  
 Other/Unknown

Marital Status (select one) \*

Single  Separated  
 Married  Widowed  
 Divorced  Unknown/Refused  
 Partnered

Race (select one) \*

American Indian/Alaskan Native  Multiracial  
 Black/African American  Other Single Race  
 White/Caucasian  Unknown/Refused  
 Asian

Hispanic/Latino Origin (select one) \*

Yes  
 No  
 Unknown/Refused

SSN \*

SSN  
Not Available

Medicare #

Medicaid #  
or Application Date

Current Living Situation

Primary Phone Number \*

Secondary Phone Number

Email Address

Confirm Email Address

Street Address \*

Apt/Unit/Suite or Other Address

City \*

State \*

Zip \*

County of Residence \*

Is the Applicant Lawfully Present in the United States?

Yes No N/A (e.g. individual is under 18) Unknown/Refused

Is the Applicant a Veteran?

Yes No Unknown/Refused

Check here if mailing Address is same as above

Mailing Street Address or PO Box

Mailing Apt/Unit/Suite or Other Address

Mailing City

Mailing State

Mailing Zip

County of Residence

### PRIMARY CONTACT DETAILS

Primary Contact First Name

M.I.

Primary Contact Last Name

Suffix (select one)

JR.  SR.  II  III

Relation to Applicant

Primary Contact Age

Email Address

Primary Phone Number

Secondary Phone Number

Street Address

Apt/Suite or Other Address Info

City

State

Zip

County of Residence



# Georgia Department of Behavioral Health and Developmental Disabilities

## Application for Intellectual/Developmental Disabilities Services

### Legal Status and Guardian

All fields marked \* are required

What is the legal status of the Applicant?

- Competent
- Emancipated
- Legally Incompetent: Documentation Required\*
- Minor
- Unknown

*\*It is mandatory to fill in Legal Guardian details for individuals with a Court appointed guardian.*

**Note: Guardianship Order from a Georgia Probate Court must be attached**

### Is Legal Guardian a \*

Person

Agency

Legal Guardian or Caseworker First Name \*

Legal Guardian Caseworker Last Name \*

Suffix (select one)

- JR.
- SR.
- II
- III

M.I.

Legal Guardian Email

Relationship to Applicant (select one) \*

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Case Worker       | <input type="checkbox"/> In-Law Relative     | <input type="checkbox"/> School                    |
| <input type="checkbox"/> Child             | <input type="checkbox"/> Neighbor            | <input type="checkbox"/> Sibling                   |
| <input type="checkbox"/> Counselor/Teacher | <input type="checkbox"/> Other Family Member | <input type="checkbox"/> Spouse/Significant Other  |
| <input type="checkbox"/> Friend            | <input type="checkbox"/> Parent              | <input type="checkbox"/> Substitute Decision-Maker |
| <input type="checkbox"/> Grandparent       | <input type="checkbox"/> Roommate            | <input type="checkbox"/> Other                     |

Legal Guardian Phone Number \*

Legal Guardian Phone Extension

Check here if Legal Guardian's Address is the same as the Applicant

Legal Guardian Street Address or PO Box

Apt/Unit/Suite or Other Address

City

State

Zip

County of Residence



# Georgia Department of Behavioral Health and Developmental Disabilities

## Application for Intellectual/Developmental Disabilities Services

### Communication

All fields marked \* are required

#### English Proficiency (select one)

- Very Well
- Well
- Not Well
- Not at All
- Unknown/Refused

#### Does the Applicant prefer to speak or use a language other than English? \*

- Yes       No      \_\_\_ Unknown/Refused      Preferred Language \_\_\_\_\_

#### What mode of communication does the Applicant utilize? (select all that apply) \*

- Communicates verbally (regardless of proficiency)
- Communication Aids (any type of device used for communication)
- American Sign Language (ASL)
- Other Manual Communication (cued speech; gestures; signed exact English; other signed languages; etc.)
- Other Communication

#### Preferred Mode of Communication (select an option) \*

- Communicates verbally (regardless of proficiency)
- Communication Aids (any type of device used for communication)
- American Sign Language (ASL)
- Other Manual Communication (cued speech; gestures; signed exact English; other signed languages; etc.)
- Other Communication

### Hearing

#### Is the Applicant deaf or does the Applicant have serious difficulty hearing? \*

- Yes                      No                      Unknown/Refused

#### Is there indication from sources other than the Applicant (e.g. third-party report; interviewer's observation; medical records, etc.) that the Applicant has hearing loss?

- Yes                      No                      Unknown/Refused

### Vision

#### Is the Applicant blind or does the Applicant have serious difficulty seeing, even when wearing glasses/contacts? \*

- Yes                      No                      Unknown/Refused



# Georgia Department of Behavioral Health and Developmental Disabilities

## Application for Intellectual/Developmental Disabilities Services

### IDD Diagnosis

All fields marked \* are required

Does the Applicant have a confirmed Intellectual and/or Developmental Disability Diagnosis?

Yes       No       Unknown/Refused

### Referral/Resources

Select Applicant Referral Source \*

\_\_\_\_\_

Referral Source Name \*

\_\_\_\_\_

Current Resources Selection \*

- |  |  |   |
|--|--|---|
| Adoption Assistance                      | HIPP (Health Insurance Premium Payment Prog) | Railroad Benefits   |
| CAPS (Subsidized Child Care Assist)      | Housing Assistance (Section 8, HPRP)         | SOURCE (Source Options Using Resources in a Comm Environment) |
| CBAY (Comm Based Alternatives for Youth) | ICWP (Independent Care Waiver Prog)          | SSDI  |
| CCSP (Comm Care Services Prog)           | MAO (Medical Assistance Only)                | SSI   |
| Deeming Waiver (Katie Beckett)           | Medicaid                                     | TANF (Temp Assist for Needy Families)                         |
| Employment                               | Medicare                                     | Ticket to Work  |
| Food Stamps (SNAP)                       | PASS (Plan for Achieving Self Sup)           | Veterans Assistance/Benefits                                  |
| FQHC (Federally Qualified Health Ctr)    | PeachCare for Kids                           | Vocational Rehabilitation                                     |
| GAPP (Georgia Pediatric Prog Waiver)     | Private Insurance                            | Other   |

Applicant's Monthly Gross Income \*

### Physician Details

All fields marked \* are required

Physician Name

Email

Street Address/PO Box

Apt/Unit/Suite or Other Address Info

City

State

Zip

Phone Number

Phone Extension

Fax Number



# Georgia Department of Behavioral Health and Developmental Disabilities

## Application for Intellectual/Developmental Disabilities Services

### Application Supporting Documents

All fields marked \* are required

Please ATTACH supporting documentation to verify Medicaid eligibility, lawful presence, and a qualifying diagnosis or condition. An application is complete for DBHDD review when required documents are received by mail or documents are attached to accompany the web application.

#### Document Type

Birth Certificate or Permanent Resident Card \*

Other Medical or Diagnostic Reports

Social Security Benefit Letter \*

Developmental Evaluation

Psychological Evaluation \*

Social Security Card \*

Medicaid \*

School IEP Report \*

Vocational/Support Employment Records

Medicare Card (if applicable) \*

School Transcript

Release of Information and/or Guardianship Documents

*If the applicant does not have social security card, Medicaid or Medicare, documentation of lawful presence can include: a birth certificate or unexpired permanent resident card. A description of documentation of lawful presence can be found at: <http://www.mmis.georgia.gov>. To access this information, please point to the 'provider information' menu and select 'provider manuals'. The criteria can be found in the 'Comprehensive Supports Waiver Program Part II manual.'*

### Application Signature

All fields marked \* are required

Last Name

First Name

M.I.

Date

#### Application Completed By

Applicant

Guardian

Family Member

Other (agency, etc.)

\_\_\_\_\_

Printed Name

\_\_\_\_\_

Please indicate the preferred method of contact

Email Address

Phone

Email Address

Primary Phone Number

\_\_\_\_\_

\_\_\_\_\_