# ELIGIBILITY DETERMINATION AND REQUEST FOR SERVICES

Department of Health and Social Services
Division of Senior and Disabilities Services

**FOR ASSISTANCE IN FILLING OUT THIS FORM**, Call the Program Specialist Nearest You:

**South-central Office/Anchorage Phone: 269-3666; 1-800-478-9996; Fax 269-3689**
**Northern Office/Fairbanks Phone: 451-5045; 1-800-770-1672; Fax 451-5046**

## A. INFORMATION ON THE PERSON NEEDING SERVICES

1. Name: _____ _____ _____
   Last Name First Name M.I.

2. Address: _____ _____
   Street Address Mailing Address (if different)
   City: _____ State: Alaska Zip: -

3. Phone Number: (907) - Message Number: (907) -

4. Sex: ☐ Male ☐ Female

5. Marital Status: ☐ Never Married ☐ Married ☐ Divorced

6. Date of Birth: _____ Place of Birth: _____ _____
   City State

8. Ethnicity:
   ☐ Alaska Native ☐ Caucasian
   ☐ African-American ☐ Hispanic
   ☐ Asian ☐ Other

9. Name of Legal Guardian: _____

10. Guardian's Address: _____
    City: _____ State: Alaska Zip: -

11. Home Telephone: (907) - Work Telephone: (907) -

If determined eligible to receive Developmental Disability Services do you want to be added to the waitlist? ☐ Yes ☐ No

If yes, When? _____
Date

**In order for your application to be completed and for your name to be added to the Waitlist it is necessary to fill out the Waitlist Criteria Assessment *in addition* to this form (attached).**

## B. SERVICE INFORMATION

(All questions in this section are directed toward the person with disabilities who is requesting service.)

1. What services or supports do you need?

2. How soon do you need these services?

☐ NOW ☐ 6 months ☐ 1 year ☐ 2 years
☐ 3 years ☐ 4 years ☐ 5 years ☐ Other _____
Specify Date

3. What agencies or people in your community are helping you now?

4. Why are you requesting services at this time?

5. In what community will you need the services and supports you are requesting?

6. Are there any particular agencies or people you would like to provide the services and supports you need? Are there any special conditions you would like to place in these services?

7. Please Check if the person needing service has received any of the following in the past six months.

- ☐ Medicaid coupons
- ☐ SSI (Supplemental Security Income) Amount _____
- ☐ AD Aid to the Disabled Amount _____
- ☐ Public Assistance Amount _____
- ☐ Food Stamps

## C. FUNCTIONAL ASSESSMENT

Describe the applicant's ability to perform the skills in the following areas of major life activity compared to a person of the same age who does not experience a disability (e.g., compare and contrast levels of independence, need for on-going support and assistance, etc.)

☐ 1. SELF CARE

What kind of assistance do you need, if any, for eating, dressing, and toileting?

☐ 2. EXPRESSIVE & RECEPTIVE LANGUAGE

What is your primary means of communicating with others? Describe any special supports or assistance you use for communicating with other people.

☐ 3. LEARNING

What is the easiest way for you to learn new information and skills? Do you need extra help of support to make learning easier?

☐ 4. MOBILITY

Describe any special equipment or assistance you need to move from one place to another at home, work, or in the community.

☐ 5. SELF DIRECTION

What kinds of decisions are you able to make on your own? Describe any support or assistance you rely on to help make decisions, or get through your daily routine.

☐ 6. CAPACITY FOR INDEPENDENT LIVING

(Only applies if age 16 years or older)
What supports do you need to live independently in your own home, do your own shopping, meal preparation, home maintenance, scheduling and keeping appointments, etc.

☐ 7. CAPACITY FOR ECONOMIC SUFFICIENCY

(Only applies if age 16 years or older)

What assistance is necessary for you to support yourself with income from a job, or through subsistence activities?

## D. ELIGIBILITY FOR SERVICES

In order to assist in determining eligibility, please attach assessments, medical evaluations, etc.

For determining the eligibility for people six years and older, a recent school or psychological evaluation that includes a full-scale I.Q. score (for people who experience mental retardation) is requested. For disabilities other than mental retardation, a physician' statement or evaluation may be used, as well as special education evaluations, and/or other comprehensive evaluations that document the existence of a disability which occurred prior to the age of 22 and is likely to last indefinitely.

If you do not have a comprehensive evaluation available, but have had one in the past, please fill out the information release on the last page of this packet so the Division may obtain the information.

**** Applications submitted without supporting documentation of disability, a signed information release, or a completed Waitlist Criteria Assessment Form cannot be processed within normal time frames, and may be returned.**

1. Please list any mental or physical impairment or combination of physical and mental impairments that have occurred before age 22, that are likely to continue indefinitely, and result in substantial functional limitations in three or more areas of major life activity.

## E. INFORMATION RELEASE AND ASSURANCES

You will need to complete a separate information release for each agency or individual you wish the Division to obtain information from. An information release form is attached. Place the name and address of the agency or individual you wish the Division to receive information from in the area designated "To:" Specify the information to be released by dating and initialing the appropriate boxes. Sign the form and return it with the application to the address of the nearest Regional Program Specialist.

Note: Failure to provide consent to release information will not prohibit provision of services to eligible individuals. It may however substantially delay the Division's determination of eligibility.

I certify that the information contained herein is correct and accurate to the best of my knowledge.

Applicant or Guardian Signature: _____

Date: _____

The individual experiencing a disability or guardian will receive a written determination of eligibility for services and confirmation that services will be provided, or that the individual's name was placed on a waiting list for services. If you feel an error was made in the eligibility determination, contact the Division of Senior and Disabilities Services, Developmental Disabilities Program Administrator, 350 Main Street, P.O. Box 110620, Juneau, AK 99811-0620, or telephone (907) 465-3370 within 30 days of receipt of the written eligibility determination to initiate an appeal.

**STATE USE ONLY**

DD Staff use: MR ☐ Autism ☐ CP ☐ Epilepsy ☐

Eligible Per AS 47.80.900 Prior to 7/28/92 Yes ☐ No ☐

| | ICD-9-CODE | Date of Onset M | D | Y |
|---|---|---|---|---|
| 1. | ☐☐☐-☐☐ | ☐ | ☐ | ☐ |
| 2. | ☐☐☐-☐☐ | ☐ | ☐ | ☐ |
| 3. | ☐☐☐-☐☐ | ☐ | ☐ | ☐ |
| 4. | ☐☐☐-☐☐ | ☐ | ☐ | ☐ |

Applicant Name: _____

Date Determined Eligible: _____

Date Eligibility Denied: _____

Developmental Disabilities Program Specialist Signature: _____

Date Eligibility Letter Sent: _____

Placed on Waitlist: Yes ☐ No ☐

# CONSENT FOR RELEASE OF RECORDS

Regarding: _____ _____

To: Release Information To: DSDS (For Patient Care)

_____ I hereby request and authorize you to release to DSDS all information you have pertaining to me as specified below.

I hereby request and authorize DSDS to release to you all information they have pertaining to me as specified below.

| Information | Date | Names/City/ State/Zip Where applicable | Client/ Guardian Initials | Information | Date | Names/City/ State/Zip Where applicable | Client/ Guardian Initials |
|---|---|---|---|---|---|---|---|
| School Evaluations | | | ❋ | Medical Records | | | ❋ |
| Other Academic Information | | | | Psychosocial Evaluations | | | ❋ |
| Psychological Evaluations | | | ❋ | Substance Abuse Treatment Records | | | |
| Psychiatric Evaluations | | | | Past Employment History | | | ❋ |
| Social History | | | ❋ | Financial Records | | | ❋ |
| Hospital Records & Discharge Summaries | | | ❋ | Most Recent Treatment Plan, (IHP, IEP, IPP,etc.) | | | ❋ |
| GPS Locations | | | ❋ | | | | |
| EMS & Utilities | | | ❋ | | | | |
| Other (Specify) | | | | Other (Specify) | | | |

This consent is subject to revocation in writing at any time. This consent is valid from ____/____/_____ through _____/____/_____ and will expire on _____/_____/_____, unless revoked earlier.

Prohibition of re-disclosure: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Law Regulations (42 CFR PART 2) prohibit you from making any further disclosers of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is not sufficient.

_____ _____
Client Signature Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Witness Signature Date

Consent (1/29/03)