

**INSTRUCTIONS
For
ELIGIBILITY DETERMINATION &
REQUEST FOR SERVICES**

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

This booklet is designed to take you step by step through the application process of requesting services through the Senior and Disabilities Services (SDS).

The application is divided into five sections (A-E).

Section A:

INFORMATION ON THE PERSON NEEDING SERVICES - such details as name, address, and pertinent client and guardian statistics.

Section B:

SERVICE INFORMATION - ask who is currently assisting the applicant, what else is needed, who might provide the assistance, in what town or village should the assistance be given, and what changes have occurred that make services necessary at this time.

Section C:

FUNCTIONAL ASSESSMENT - attempts to create a picture of the supports needed by the applicant in seven areas of life tasks.

Section D:

ELIGIBILITY FOR SERVICES - documentation necessary to establish a developmental disability as defined by Alaska state statute.

Section E:

INFORMATION RELEASE AND ASSURANCES - authorizes the SDS to contact the reference source listed on the information release.

If you have any questions regarding the intake application form, or need assistance with a particular question or section, call the Health Program Manager in your region listed below.

Health Program Manager
Fairbanks Office
751 Old Richardson Highway, Suite 100A
Fairbanks, AK 99701
(907) 451-5045 1-800-770-1672
TTY: (907) 451-5093

Health Program Manager
Anchorage Office
550 W. 8th Ave
Anchorage, AK 99501
(907) 269-3666 1-800-478-9996
TTY: (907) 269-3624

Collect calls will be accepted, or leave a message and a Health Program Manager will return your phone call.

The State definition of a developmental disability is found on the last page of this booklet.

SECTION A: INFORMATION ON THE PERSON NEEDING SERVICES

1. **Name:** List the applicant's last name, then first name, then middle initial if applicable. The applicant is the person experiencing the disability who is applying for services, *not* the parent, guardian, or other legal representative who may be completing the form on the applicant's behalf.
2. **Address:** List the address where the applicant receives correspondence.
3. **Telephone Number:** List the telephone number where the applicant physically resides if different from the number of the legal guardian. Please indicate if this is a message phone number, house phone number, or work number.
4. **Sex:** Check appropriate box.
5. **Marital Status:** Check appropriate box.
6. **Date/Place of Birth:** The dates can be in numbers (01/01/90). Indicate name of town or city, and state in which applicant was born.
7. **Ethnicity:** Indicate ethnic background of applicant.
8. **Name of Legal Guardian:** If the applicant is not his or her own guardian, name the court appointed person who is responsible for making legal decisions for the applicant, even if only partial guardian *or* conservator.
9. **Guardian's Address:** List all information, even if the person completing the form is not the guardian.
10. **Guardian's Telephone:** Include both home and work telephone numbers, if possible.

11. Self Designated Support (optional):

If applicant does not have a legal representative, provide the contact information of anyone who assists the applicant. We will copy your eligibility and Registry mail to the person indicated. **Ensure this name is also listed on the *Release of Information* and that the *Release of Information* is updated annually.** Forms can be found at <http://www.hss.state.ak.us/dsds/dd/default.htm>.

SECTION B: SERVICE INFORMATION

NOTE: The person who needs support and is the one to receive services (the applicant) should, if at all possible, be very involved in filling out this portion of the intake form

1. **What services or supports do you need?**
 - List the kinds of activities, housing arrangements, additional caregivers, or any other type of supports that would enable the applicant to get the supports they feel they need.
2. **How soon do you need these services?** Some people need assistance as soon as it can be provided because life circumstances have changed; others need only temporary short-term assistance while waiting for a place to live or work.
 - Indicate how far in the future or by what date you need the supports listed in Item B.1.
3. **What agencies or people in your community are helping you now?**
 - Indicate the people who currently assist the applicant in the community. This helps SDS determine if there are supports that you may be eligible for but are not currently receiving.
4. **Why are you requesting services at this time?**
 - Have circumstances changed in the life of applicant? Is the request for services a part of a future planning effort rather than a reaction to a significant change?
5. **In what community will you need the services and supports you are requesting?** One of the most basic freedoms of choice issues is where one chooses to live.
 - What Alaskan city or village you would like to live in to receive the supports listed in question 1.?
6. **Are there any particular agencies or people you would like to provide the services and supports that you need? Are there any special conditions you would like to place in these services?** In some Alaskan communities specific services exist for people who experience a developmental disability. In most places the State does not have a grant available to provide services. In many communities there are people who have been assisting the individual who is requesting services. It is possible, in some cases, to utilize these natural helpers by providing them training, income, and other professional supports. The only

restriction is that helpers not live in the natural family home with the person needing help.

Because a service is in a community that has a State grant it does not necessarily mean that one has to settle for what is available from that program. We will attempt to provide you with the supports you want and need through changing existing services or creating new ones. Individuals do not have to accept a service just because it is one that exists at the current time. Many individuals have values and preferences that are important to their culture or family. Whenever possible we would like to be made aware of these values so they can be made a part of the delivery of services to the individual.

7. **Please check if the applicant is currently receiving or has received any of the following in the past six months.**

The information will be used to determine if the applicant is getting all of the benefits they are entitled to receive. NOTE: The amount of income received from the programs is utilized by SDS staff when assisting families in planning for services. The dollar amount received from each program is not required information and you may leave it blank if you wish.

SECTION C: FUNCTIONAL ASSESSMENT

Eligibility requires that an individual be substantially limited in three of the seven activities of daily living. Carefully describe how much assistance or what supports must be provided for the applicant to successfully complete each activity area. If you are assisting an applicant who cannot sign the form, list your relationship to the applicant.

The boxes to the left of the questions are used by the SDS staff to indicate if the life area, in their judgment, is substantially impaired.

1. **What kind of assistance do you need, if any, in eating, dressing, and toileting.**

List the types adaptive devices or specialized procedures necessary for the applicant to accomplish activities of daily living.

Examples: Assistance cutting food because the applicant cannot; or the applicant requires a special cup to enable consumption of liquids; assistance in dressing, the applicant must be told to put on a coat in cold weather; toileting assistance may be reminding the applicant to toilet or taking the applicant to the toilet to help with hygiene procedures.

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

Does the applicant need assistance to speak, write, or read? Can the applicant follow spoken or written directions? In order to communicate does the applicant require assistance of a special communication board, someone who can use sign language, or some other form of special support?

3. **What is the easiest way for you to learn new information and skills? Do you need any extra help or support to make learning easier?**

In what manner does the applicant learn and retain information the best? Drawing on your past experience, what is the best way to teach the applicant a new skill? In

teaching the skill, what would you do differently that you would not do when teaching a person who does not experience a disability?

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

Describe the equipment, such as a wheelchair, brace, or walker and any specialized service such as car with a lift or adaptations to a building such as a ramp, that make it possible for the applicant to have access to the local community.

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

Does the applicant make decisions about paying bills, what to prepare for dinner, who should be their friends or housemates? Does the applicant need a conservator or payee to help with paying bills?

Has the court appointed a guardian or a conservator? Does the applicant have a representative payee? What kinds of decisions does applicant need support or assistance in making?

6. **What supports do you need to live independently in your home; do your own shopping, meal preparation, home maintenance, scheduling and keeping appointments, etc.?**

What services or individuals assist in accomplishing tasks that would ordinarily be done by the applicant if they did not experience a disability? Examples of services: homemakers; home health care; assistance grocery shopping.

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

Does the applicant require supports to maintain employment? Example: job coach; a specially trained supervisor; tasks that the applicant does part and another person completes.

SECTION D: ELIGIBILITY FOR SERVICES

Once a completed application form has been provided to SDS, SDS qualified mental retardation professional (QMRP) will determine eligibility for services based upon the following definition and interpretation of AS 47.80.900:

A “person with a developmental disability” means a person who is experiencing a severe, chronic disability that:

- 1) Is attributable to a mental or physical impairment or combination of mental and physical impairments;
- 2) Is manifested before the person attains age 22;
- 3) Is likely to continue indefinitely;
- 4) Results in substantial functional limitations in three or more of the following areas of major life activity:
 - i) Self-care,

- ii) Receptive and expressive language,
 - iii) Learning,
 - iv) Mobility,
 - v) Self-direction,
 - vi) Capacity for independent living,
 - vii) Economic self sufficiency; and
- 5) Reflects the individual's need for a combination and sequence of special interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated.

Often the applicant may have other diagnoses, whether associated with the disability or not, which are helpful in determining the scope of supports required. The division may be able to refer the individual to other resources, which may be of assistance.

Mental or physical impairments caused by mental illness are not considered a developmental disability. This would include all mental illness diagnosis that is coded on Axis I using the Diagnostic and Statistical Manual of Mental Disorders III-R.

Documentation of the applicant's disability is necessary to allow Senior & Disability Services to complete the eligibility assessments. Medical records are only one source of verifying a disability. School district records, public health records, or any responsible, professional assessment will be utilized in determining eligibility for services. Please send any evaluation you already have, rather than getting a new one if it is at all possible.

For older children and adults, measurable and objective evaluations are usually easy to obtain. A pediatrician, infant learning specialist, or public health nurse can rate the percentage of developmental delay in chronological terms that will show comparisons in a child's fine motor, gross motor, learning and communication development.

For children, who because of multiple health impairments standardized testing is not valid, a medical review/description of the child's health impairments with a statement of their life long nature will be necessary to determine the child's developmental delay.

Documentation will be necessary to determine eligibility. Please ignore the information below the double line on page seven of the application, as this section will be used by State personnel.

SECTION E: INFORMATION RELEASE AND ASSURANCES

Signing the release form will allow the Developmental Disabilities Program Specialist/Qualified Mental Retardation Professional to contact the agency you have listed on the release form so that information may be obtained to complete the eligibility determination.

The bottom of page seven under STATE USE ONLY on the application is used to document the eligibility decision.

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?

- | | | | |
|----------------------------------|-----------------------------------|----------------------------------|----------------------------------|
| <input type="checkbox"/> NOW | <input type="checkbox"/> 6 months | <input type="checkbox"/> 1 year | <input type="checkbox"/> 2 years |
| <input type="checkbox"/> 3 years | <input type="checkbox"/> 4 years | <input type="checkbox"/> 5 years | <input type="checkbox"/> 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 you have 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 Amount _____

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. If you feel an error was made in the eligibility determination, contact Senior and Disabilities Services, Health Program Manager III 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.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	- <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	- <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	- <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	- <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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 disclosures 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 _____ Date _____

Witness Signature _____ Date _____