



OKLAHOMA DEPARTMENT OF HUMAN SERVICES



Request for Developmental Disabilities Services

Date	County	OKDHS case number
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This form is used to apply for services to persons with developmental disabilities through OKDHS Developmental Disabilities Services Division (DDSD). This application does not address financial eligibility requirements for Medicaid funded DDSD services.

Section 1. Applicant

Applicant legal last name		First	Middle	Home phone ()
Street address		City	State	Zip
Also known as		Date of birth		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Race	Home phone ()	Social Security number, attach copy of card		
United States citizen <input type="checkbox"/> Yes <input type="checkbox"/> No		Resident alien <input type="checkbox"/> Yes <input type="checkbox"/> No		
Marital status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced		Language spoken or understood by applicant		
Applicant employed <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, employer is		

Completed by state employee only

Who has legal custody?		County of adjudication	Adjudication date
Primary worker	Work phone ()	Supervisor	Work phone ()
If OKDHS or Office of Juvenile Affairs (OJA) has legal custody, attach copy of order. Type: <input type="checkbox"/> Temporary <input type="checkbox"/> Permanent			

Section 2. Parents/guardian

Father		Home phone ()	Work phone ()
Street address		City	State Zip

Mother		Home phone ()	Work phone ()
Street address	City	State	Zip
Legal guardian		Home phone ()	Work phone ()
Street address	City	State	Zip
Primary correspondent, if different			Relationship
Street address, if different	City	State	Zip
Secondary correspondent			Relationship
Street address	City	State	Zip

Section 3. Household members

Name	Relationship	Date of birth	Occupation	Health status

Section 4. Medical

Attach copy of applicant's birth certificate.

Hospital or facility where applicant was born			
Street address	City	State	Zip

1. Briefly describe any significant medical problems/disabilities experienced by applicant.

2. Who is applicant's current primary care physician? _____

3. Does applicant take any routine medications? Yes No
If yes, list medications, dosage, and reason for medications.

4. Has applicant been diagnosed with mental retardation, autism, or mental illness? Yes No

If yes, list diagnosis	When	By whom

5. Has applicant had a psychological evaluation? Yes No
Attach copy, if available.

If yes, when	Where	By whom	I.Q.	Mental age

Describe any behavioral problems:

Section 5. Education

Is applicant currently attending school? Yes No

If yes, where	Special class	Regular class	Grade

Copy of applicant's current individualized education plan (IEP) available? Yes No
If yes, attach copy.

If out of school, where did applicant attend school? _____

Briefly describe applicant's adjustment to school regarding peer interaction and relationships with teachers.

Section 6. Additional information

Services currently receiving from the school, community, and other agencies:

Check all that apply. Currently receiving: Supplemental Security Income (SSI)
 Social Security Administration (SSA) payment Medicaid Medicare

Requested DDSD services:

- Home and Community-Based Services (HCBS)
- eligibility for state-funded group home/assisted living without waiver supports
- state-funded workshop/community integrated employment

What kind of help do you need?

I authorize OKDHS to make this application available for evaluation services to agencies designated by OKDHS. I further agree to comply with all applicable laws, rules, and regulations, and understand that services and benefits for persons with developmental disabilities are equally available to all persons without regard to race, color, religion, or national origin. I understand that I may cancel or withdraw this application for services by submitting written request to the appropriate DDSD area office.

The information in this application is correct to the best of my knowledge:

Legally responsible party/applicant signature

Date

If applicant is age 18 or older and does not have a legal guardian:

Person assisting applicant signature

Date

OKDHS action regarding this application must occur within 180 days from the date of receipt by OKDHS of the completed application. When state DDSD resources are unavailable to serve new applicants in the HCBS program, they are placed on a statewide waiting list.

Return to DDSD office in the area where applicant resides.

DDSD Area I Office

729 Overland Trail
Enid, OK 73703

Toll free: 1-800-522-1064

DDSD Area I Office

4545 N. Lincoln Boulevard
Oklahoma City, OK 73105

Toll free: 1-800-522-1064

Covers: Alfalfa, Beaver, Blaine, Canadian, Cimarron, Custer, Dewey, Ellis, Garfield, Grant, Harper, Kay, Kingfisher, Lincoln, Logan, Major, Noble, Oklahoma, Payne, Roger Mills, Texas, Woods, and Woodward

DDSD Area II Office

1427 East 8th
Tulsa, OK 74120

Toll free: 1-800-522-1075

Covers: Adair, Cherokee, Craig, Creek, Delaware, Mayes, McIntosh, Muskogee, Nowata, Okfuskee, Okmulgee, Osage, Ottawa, Pawnee, Rogers, Sequoyah, Tulsa, Wagoner, and Washington

DDSD Area III Office

301 South Indian Meridian Road
Pauls Valley, OK 73075

Toll free: 1-800-522-1086

Covers: Atoka, Beckham, Bryan, Caddo, Carter, Choctaw, Cleveland, Coal, Comanche, Cotton, Garvin, Grady, Greer, Harmon, Haskell, Hughes, Jackson, Jefferson, Johnston, Kiowa, Latimer, LeFlore, Love, Marshall, McClain, McCurtain, Murray, Pittsburg, Pontotoc, Pottawatomie, Pushmataha, Seminole, Stephens, Tillman, and Washita

