DHS
Oregon Department of Human Services
Seniors and People with Disabilities

Intake Application for Development Disability Services

For office use ONLY	
County receiving application:	Date received by county:

Applicant information

Last name: (please print)		First name:		Middle initial:
Physical address:		City:	State:	ZIP:
Mailing address: (if different)		City:	State:	ZIP:
Phone number:	Gender: ☐ M ☐ F	Date of birth:	Social Security Number:	
Applicant's primary language:		Birthplace:	Marital status:	
Other names used: (birth name, maiden name, nick names)				
Email address: (optional)				

Are you a US Citizen or a permanent resident of the United States? (Permanent residency applies to people lawfully admitted to the United States for permanent residence.)
☐ Yes ☐ No Date of permanent residency:

Applicant's ethnicity: (optional)	☐ Hispanic	☐ Not Hispanic	☐ Unknown
Applicant's race: (optional)	☐ Asian	☐ African American	☐ Black
	☐ Alaska Native	☐ Native American	☐ Native Hawaiian
	☐ Pacific Islander	☐ White	☐ Other/unknown

Reason for application: (What services are being requested?)	
Referral person: (name)	Phone number:

Other developmental disability services

Have you ever applied for or received services from a developmental disabilities program in the State of Oregon or outside of Oregon? ☐ Yes ☐ No
If yes, in which Oregon county(s) or other states?

Guardian

IF APPLICANT HAS A COURT ORDERED LEGAL GUARDIAN, DOCUMENTATION OF LEGAL GUARDIANSHIP MUST BE PROVIDED AT TIME OF APPLICATION

Does the applicant have a court ordered legal guardian? ☐ Yes ☐ No
If yes, list name, address and phone number:
Location of court?

Alternate contacts

Parent/guardian name(s):	Parent/guardian phone number:	Relationship:
Parent/guardian address:	Parent/guardian email address:	Relationship:
Emergency contact name:	Emergency contact phone number:	Relationship:
Emergency contact address:	Emergency contact email address:	Relationship:

Disabilities (check all that apply)

Condition	Check if applicable	Briefly describe current function and support, specific diagnoses, etc.
Intellectual disability/Mental Retardation	☐	
Cerebral Palsy	☐	
Autism Spectrum Disorder	☐	
Down Syndrome	☐	
Epilepsy	☐	
Motor issues	☐	
Communication	☐	
Vision impaired	☐	
Hearing impaired	☐	
Mental/emotional/ behavioral	☐	
Traumatic brain injury/ acquired brain injury	☐	

Disabilities continued (complete all that apply)

Condition	Check if applicable	Briefly describe current function and support, specific diagnoses, etc.
Prenatal exposure to drugs alcohol or other toxins	☐	
Delayed milestones (explain)	☐	
Other disability:	☐	
Other disability:	☐	

Legal

Does applicant have a criminal/juvenile court record? ☐ Yes ☐ No	
State/county of offense:	Offenses:
Parole/probation contact name:	Contact phone number:

Educational history (Did applicant receive special education, i.e. early intervention, IEP or 504 plan?)

Most recent/current school:

Special education services ever received? ☐ Yes ☐ No

Did applicant graduate from high school? ☐ Yes ☐ No — Year graduated or last grade completed:

What type of diploma was received? ☐ Regular ☐ Modified ☐ GED ☐ Certificate of completion ☐ None

Previous school: (if applicable)

Current living situation

(Examples: with family, alone, with friends, foster care, group home, nursing home.)

Describe current living situation:

History of living situations: Prior to the current living situation, have you lived anywhere else outside your own home or family home (examples: foster care, group home, nursing home, residential treatment facility)? ☐ Yes ☐ No If yes, please describe:

Financial resources (Relates only to applicant.)

Is applicant currently receiving, or have they ever applied for financial resource? (SSI, SSDI etc.) ☐ Yes ☐ No	
SSI amount:	Social Security amount:
Other:	
Does applicant need to be referred to Social Security to apply for benefits? ☐ Yes ☐ No	
Representative payee name:	Phone number:

Health insurance (Complete those that apply.)

Existing coverage: ☐ None	☐ Oregon Health Plan #: ☐ Medicare #:	Private health insurance carrier:
Does applicant need assistance applying for Medicaid/Oregon Health Plan? (Food benefits, health insurance.) ☐ Yes ☐ No		

Other service agencies: Current and previous (examples: child welfare, self sufficiency, vocational rehabilitation, mental health).

Agency name	Contact/ representative's name	Phone	Dates seen by provider

Medical/dental (Primary care physician, dentist and preferred hospital.)

Primary care physician name:	Address:	Phone number:
Dentist name:	Address:	Phone number:
Preferred hospital:	Address:	Phone number:

Medical specialist

(Examples: psychologist, psychiatrist, neurologist, developmental pediatrician, etc.)

Name and specialty:		Phone:	
Address:	City:	State:	ZIP code:
Name and specialty:		Phone:	
Address:	City:	State:	ZIP code:

Other information (Examples: IQ tests, mental health assessments, medical or genetic evaluations, vocational rehabilitation assessments, social security testing or medical assessments, etc.)

Have any tests or special evaluations been completed in the past? ☐ Yes ☐ No
If you answered yes, where can the tests or special evaluations be obtained?

Name of agency:	Contact name: (if known)	Phone number:
Name of agency:	Contact name: (if known)	Phone number:

Have you ever been hospitalized for psychiatric or medical treatment or conditions?
☐ Yes ☐ No If you answered Yes, where were you hospitalized?

Name and city of hospital: Phone number:

Notification of eligibility determination

In addition to receiving a copy of the eligibility determination notice in the mail, is there another way that you would like to be notified of the eligibility determination? ☐ Yes ☐ No
If yes, please explain:

If you would like a copy of the eligibility determination notice sent to anyone besides yourself, you must provide the name and address of this person in the space above.
A release of information must be on file in the developmental disability office in order to provide this information to anyone other than the applicant and/or legal guardian.

- Voluntary services from the Community Developmental Disabilities Program (CDDP) have been requested by the applicant or the legal guardian.
- An eligibility determination will be made within 90 days of the CDDP receiving this application.
- An extension of up to 90 days, for the CDDP to make an eligibility determination, may be mutually agreed upon under certain circumstances.
- A contested case hearing may be requested if the eligibility determination is dissatisfactory.
- A contested case hearing may be requested by legal counsel, a relative, friend or other spokesman.
- A hearing must be requested within 45 days of being notified of the eligibility determination in accordance with OAR 411-320-0175.
- A request for a contested case hearing must be made on DHS form 0443DD.

Signatures By signing below, I agree that the information is true and correct whether given by me or someone else.

Applicant or legal guardian signature Date

Name (print) Phone

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 and Human Services at 1-800-537-7697.

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