

Application and Interview Form for Developmental Disabilities Services Program

Other formats and languages:

You can get this document, SDS 0552, in other languages, large print, braille or a format you prefer free of charge. Contact Office of Developmental Disabilities Services at DD.DirectorsOffice@odhsoha.oregon.gov or 503-945-5811 (voice/text). We accept all relay calls.

For CDDP office use only:

Referral date: _____ Intake interview date: _____

CDDP: _____

☐ Initial application ☐ Reapplication

Medicaid: ☐ Yes Medicaid or Prime number: _____

☐ No, Oregon Health Plan (OHP) or Oregon Eligibility (ONE)
referral date: _____

Referral source:

☐ Self or guardian ☐ Family or friend ☐ Provider referral

☐ Community Partner ☐ Other: _____

Applicant information

Note: "you" and "your" in this document refer to the applicant.

Legal first name: _____ Middle initial: _____

Last name: _____

Other names used on records (please list): _____

Preferred name: _____ Preferred pronouns: _____

Gender: ☐ Female ☐ Male ☐ Gender identity: _____

☐ Decline to answer Date of birth: _____

Social Security number: _____

☐ No Social Security number

Citizen status is not required for ODDS eligibility. Many services do not need citizen status under the public charge rule. **See the FAQ** on the Oregon Department of Justice website: www.doj.state.or.us/oregon-department-of-justice/civil-rights/sanctuary-promise/community-toolkit/.

Marital status:

Choose one

☐ Single ☐ Married ☐ Separated
☐ Divorced ☐ Widowed ☐ Cohabiting
☐ Domestic partnership ☐ Prefer not to say

Street address or PO Box: _____

City: _____ State: _____ Zip: _____

Do you receive mail at this address? ☐ Yes ☐ No

Phone number: _____ Message number: _____

Email: _____

Who else do you want ODHS to contact?

Check as many as you want.

☐ Parent ☐ Legal guardian ☐ Primary custody

☐ Health representative (ORS 127.505)

☐ Other (describe): _____

Does anyone else have legal authority to make decisions for you?

☐ Yes (If yes, list name below) ☐ No

Relationship (for example, custodial parent, guardian):

First name: _____ Last name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone number: _____ Email: _____

Eligibility notification

Would you like a copy of the eligibility decision notice sent to anyone besides you?

☐ Yes ☐ No

If yes, to whom do you want a decision notice sent?

☐ Same person(s) listed above ☐ Other (fill in their information below)

First name: _____ Last name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone number: _____ Email: _____

ODHS must have a written authorization to:

- Release information, and
- Notify anyone other than you or your legal guardian.

Race, Ethnicity, Language and Disability (REALD) (OAR 943-070-0030)

Completing the questions in the linked form below can help ODHS learn more about you. Although optional, it may help ODHS find and address health or service differences. This allows everyone to get the highest quality of care.

[REALD-ODHS Form me0074](#) or [Form me0074b for parent or guardian of a minor](#).

The Oregon Department of Human Service (ODHS) asks everyone about their:

- Race
- Ethnicity
- Abilities
- Preferred language
- Interpreter needs

For CDDP staff only: Place completed REALD form with this application

Health and disability

ODHS asks everyone about their conditions and history. It helps find records to determine eligibility and coordinate services or care. State as much as possible about your health history. If you are not sure of dates, list dates you think are close to the time of service.

Did you apply for or receive disability services through any of these programs? Check all that apply.

☐ Intellectual and developmental disabilities (I/DD) in any state (list where)

☐ Child Welfare Date: _____

☐ Self Sufficiency Date: _____

☐ Vocational Rehabilitation Date: _____

☐ Behavioral or Mental Health Date: _____

☐ Other (list): _____

Developmental conditions

Which conditions did a provider or clinic say you have? Check all that apply.

- | | |
|--|---|
| ☐ Under age 7: Global Developmental Delay or delayed milestones | |
| ☐ Intellectual disability | ☐ Epilepsy (seizure disorder) |
| ☐ Cerebral Palsy | ☐ Down Syndrome |
| ☐ Brain injury | ☐ Autism Spectrum Disorder |
| ☐ Fetal Alcohol Spectrum Disorder | ☐ Other prenatal exposure to drugs or toxins |
| ☐ Other developmental disorders | |

What age did this begin? _____

How does your condition affect your daily life?

What support needs do you have because of your intellectual or developmental disability? Check all that apply.

- | | |
|---|---|
| ☐ Self-care | ☐ Health activities |
| ☐ Decision making | ☐ Community or social activities |
| ☐ Money management | ☐ Living at home |
| ☐ Other: _____ | |

Other conditions

Even if you don't have a developmental disability, what are your other conditions? Check all that apply.

- | | |
|---|---|
| ☐ ADHD, or other behavioral health condition | |
| ☐ Learning disorder | ☐ Motor impairment |
| ☐ Hearing loss, vision loss, or both | ☐ Substance disorder |
| ☐ Other | |

Health coverage

Do you have coverage? If you do, list the plan ID number.

- | | |
|---|-----------------------|
| ☐ Health insurance through a job | Plan ID number: _____ |
| ☐ Health insurance you pay for | Plan ID number: _____ |
| ☐ Oregon Health Plan (OHP) | Plan ID number: _____ |
| ☐ Medicaid | Plan ID number: _____ |
| ☐ Medicare | Plan ID number: _____ |
| ☐ No health coverage | |

Provider information and records

Which providers or clinics gave you the following?

- Evaluations or assessments
- Tests that told you have the above conditions, or
- Other information about your conditions.

These may be:

- | | |
|----------------------|-------------------------------|
| • Psychologists | • Developmental pediatricians |
| • Neuropsychologists | • Geneticists |
| • Psychiatrists | • Mental health providers |
| • Neurologists | |

For example, list a provider or clinic you have seen for an IQ test, psychological evaluation, medical or genetic evaluation of your disability, or mental health assessment.

Example of how to fill out your information:

Dates seen: 2016-2020

Provider or clinic name: OHSU-Sam Jackson Blvd, Portland

Diagnosis or type of evaluation: Autism Clinic Evaluation - follow up

Provider information 1

Dates seen: _____

Provider or clinic name: _____

Diagnosis or type of evaluation: _____

Provider information 2

Dates seen: _____

Provider or clinic name: _____

Diagnosis or type of evaluation: _____

Provider information 3

Dates seen: _____

Provider or clinic name: _____

Diagnosis or type of evaluation: _____

Primary care physician information

Who is your primary care physician (PCP) ? What is their address, phone number, and email, if available?

Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Other provider information 1

Who are your other providers? What are their addresses, phone numbers, and emails, if available?)

Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Other provider information 2

Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Hospitals and care centers

Have you ever stayed in a center or hospital because of your disabilities?

☐ Yes ☐ No

Sometimes, ODHS needs information or records from those places.
List them below.

Hospital or care center 1

Date: _____

Name of the facility or hospital: _____

Location of the facility or hospital: _____

Hospital or care center 2

Date: _____

Name of the facility or hospital: _____

Location of the facility or hospital: _____

Hospital or care center 3

Date: _____

Name of the facility or hospital: _____

Location of the facility or hospital: _____

Income

What is your income, and where is it from? Check any that you get. List only your income; do not include other household income.

☐ Employment

☐ Private disability benefits

☐ Child support received

☐ Temporary Assistance for Needy Families (TANF)

☐ Trust fund

☐ Veteran's benefits

☐ Achieving a Better Life Experience (ABLE) account

☐ Adoption or guardianship assistance

☐ No income

☐ Other: _____

If you **do not have** an ABLE account and would like to learn more about this plan, visit: oregonablesavings.com

Other information

What other information about you may be helpful to know?

Social Security

Some people with disabilities may qualify for federal disability programs managed by the Social Security Administration (SSA):

- Social Security Disability Insurance (SSDI), or
- Supplemental Security Income (SSI).

Do you currently get any type of Social Security benefits? ☐ Yes ☐ No

If yes, when did you begin getting benefits? _____

Social Security Disability Insurance (SSDI) amount? \$ _____

What is the Supplemental Security Income (SSI) amount? \$ _____

If you do not get SSDI or SSI, have you applied for Social Security benefits?

☐ Yes, pending ☐ Yes, denied ☐ No

SSDI or SSI application date: _____

You can learn more on the [Social Security website](#) if you need to apply for, reapply for, or appeal a denial for SSDI or SSI benefits. You can also contact your [local SSA office](#) to apply.

These resources may be helpful:

- Understanding SSI: socialsecurity.gov/ssi/text-income-ussi.htm
- SSI payment amounts: ssa.gov/oact/cola/SSI.html

Education history

☐ Is the applicant a child younger than 5 and not in Early Intervention (EI) or school? **If you check this box, skip this section.**

What are your most recent schools and early intervention through college?

Name of current or most recent school or EI program:

Start date: _____ End date: _____

City: _____ State: _____

Name of previous school:

Start date: _____ End date: _____

City: _____ State: _____

Have you ever received special education services at any school?

☐ Yes ☐ No

Examples are:

- Early intervention
- Individualized Family Service Plan (IFSP)
- Individualized Education Program (IEP), or
- 504 plan.

If yes, what types of services? Check all that apply.

☐ Physical therapy ☐ Speech therapy ☐ Occupational therapy

☐ Transition services ☐ Specialist testing or evaluations

☐ Other: _____

Are there other schools, types of disability services, or details that may help ODHS with your disability information?

What type of diploma did you get if you graduated from high school?

☐ Not applicable N/A ☐ Regular ☐ GED ☐ Modified

☐ Certificate ☐ Didn't graduate ☐ Unknown

Legal history

Do you have a criminal record or juvenile court record? ☐ Yes ☐ No

If yes, fill out the following information:

State and county of offense: _____

Name the offense: _____

Parole or probation officer name: _____

Phone number: _____

Other legal information:

Signature

By signing below, you state that the information in this application is true and correct, whether given by you or a representative. You also confirm you received and reviewed your rights located after this section.

Signature or mark: _____ Date: _____

Print name: _____

Relationship to applicant: _____

- ☐ Self (adult applicant) ☐ Adult's court-appointed guardian
☐ Minor's custodial parent or legal guardian

Notices, rights and your information

The Oregon Department of Human Services does not discriminate.

ODHS serves every applicant who qualifies for services. ODHS will not treat applicants differently because of age, race, gender, color, national origin, religion, political beliefs, disability or sexual orientation. If you believe ODHS treated you unfairly, you may file a complaint with the Governor's Advocacy Office at **800-442-5238**.

Why we need your Social Security number

Federal laws, 42 USC 1320b-7(a) and (b), 42 CFR 435.910, 42 CFR 435.920, and 42 CFR 457.340(b) and OAR 461-120-0210 require applicants to give ODHS and the Oregon Health Authority (OHA) a Social Security number (SSN) on applications for medical benefits, except as stated in OAR 461-120-0210. **ODHS and OHA will use your SSN to help decide if you are eligible for benefits.** ODHS and OHA may use your SSN to match the information on your application with records of other state and federal programs and agencies, such as:

- IRS
- Medicaid
- Social Security
- The Oregon Employment Department

ODHS and OHA may also use your SSN to prepare combined data or reports for funding agencies about programs you apply for and benefit from. Specifically, ODHS and OHA may use or disclose your SSN to funding agencies:

- Operate the program you apply to or benefit from
- Conduct quality assessment and improvement activities
- Verify the correct payment amounts
- Do business with providers
- Recover overpaid benefits

Protecting your information

CDDP and ODHS will protect your information and records. They do so per ODHS's privacy and security policies, ORS 179.505 and ORS 179.507. CDDP needs your authorization to request and release records related to your disability.

Other application related information

- Applying is voluntary; **you or your legal representative may withdraw this request anytime.**
- For more information about ODDS services, please review the "Choosing Developmental Disability Services for Children and Adults" brochure ([form de0338](#))
- Intake is complete when you sign this form, submit it and the release-of-information forms, and complete an interview with the CDDP in the county where you or your guardian (for a minor child) live.
- Intake and completed application are defined in [OAR 411-320-0020](#).
- Most decisions are made within 90 days unless more time is needed. **You must work with your local CDDP to complete the application and provide the required documents.** CDDP may ask you to attend a diagnostic evaluation per ORS 410.060 and 427.105.
- A completed application, as described in [OAR 411-320-0080](#), means CDDP has what it needs to make an eligibility decision. This form:
 - ▶ Releases, and
 - ▶ All documents and records necessary.CDDP will send you a written decision notice within 10 days of the completed application.
- Decision notices contain a notice of hearing rights. If you disagree with CDDP's decision, you may request a contested case hearing anytime. Details are in ORS Chapter 183 and OAR 411-318-0025. To make a hearing request:
 - ▶ Fill out an Administrative Hearing Request Form ([SDS 0443DD](#)), or
 - ▶ Make a verbal request to a CDDP or ODHS employee.

Print

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