



Intellectual and Developmental Disabilities Services Request and Application

Purpose: Request services and supports for adults with intellectual and developmental disabilities.

Mission: The Department on Disability Services (DDS) provides innovative high-quality services that enable people with disabilities to lead meaningful and productive lives as vital members of their families, schools, workplaces, and communities in every neighborhood in the District of Columbia.

You must meet BOTH requirements to receive services:

DC Resident

Person with an intellectual or developmental disability

Submission Instructions

1. Complete this form

2. Collect photocopies of these **required** documents:

- Birth certificate or state ID
- Social security card (if available)
- Proof of DC residency (i.e. current lease or utility bill, official Social Security statement)
- Medical Records documenting the diagnosis of a developmental condition, if applicable

Collect the following documents (if available):

- Psychological evaluations documenting an intellectual or developmental disability
- School Records/Individual Education Plan (IEP)
- Psychiatric Evaluations
- Speech Language Evaluations
- Occupational Therapy Evaluations
- Physical Therapy Evaluations
- Vocational Assessments
- Current physical or medical form from doctor

I would like DDS to assist me in gathering these documents.

3. Submit the form and documents in one of the following ways:

- **Email** (as a PDF attachment) to: dds-dda.intake@dc.gov
- **Mail** addressed to: Department on Disability Services, Intake Department, 250 E Street, SW, Washington, DC 20024
- **In person** to: 250 E Street SW, Washington, DC 20024 | M-F, 8:30 am – 5:00 pm

DC Department on Disability Services | Contact 202.730.1700 for help with this form.

Intellectual and Developmental Disabilities Services Request and Application

Person Who Would Receive Services			
First Name:	Last Name:	DOB:	
Email:	Phone:	SSN:	
Address:		Washington, DC	ZIP:
Medicaid #:		<input type="checkbox"/> Please provide assistance registering for Medicaid.	

Family Member/Supporter/Caregiver			
First Name:	Last Name:		
Relationship:	Email:	Phone:	
Address:	City:	State:	ZIP:

What services and supports are needed?
<small>This information will help DDS begin a conversation with you about an appropriate service plan.</small>

Signature		
I declare that the statements made above are true and accurate to the best of my knowledge, information and belief. Any significant changes in these circumstances will be made known to DDS immediately.		
Check One:	<input type="checkbox"/> Person Requesting Services	<input type="checkbox"/> Legal Guardian
		<input type="checkbox"/> Durable Power of Attorney
Applicant's Name:	Applicant's Signature:	Date:
Name:	Signature:	Date:

You will be notified when your application is complete.

For Referral Source Use Only	
Referral Organization:	<input type="checkbox"/> CFSA <input type="checkbox"/> DCPS <input type="checkbox"/> HSCSN <input type="checkbox"/> Other:
Referrer Name:	Phone:

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Consent to Obtain or Release Record Information

DDS may need additional information to establish eligibility or develop an appropriate service plan. By completing this form, you are authorizing DDS to contact doctors and/or organizations on your behalf.

Person Who Would Receive Services			
First Name:	Last Name:	DOB:	
Address:		Washington, DC	ZIP:

Consent to the following records being released <i>(check all that apply)</i> :		
<input type="checkbox"/> Individual Educational Plan (IEP)	<input type="checkbox"/> Vocational Assessments	<input type="checkbox"/> Other:
<input type="checkbox"/> Behavior Support Plan (BSP)	<input type="checkbox"/> Psychological Evaluations	<input type="checkbox"/> Other:
<input type="checkbox"/> Health Record	<input type="checkbox"/> Labs/Clinical/Health Data	<input type="checkbox"/> Other:
<input type="checkbox"/> Health Care Management Plan		

Records disclosed by:			
What are the 3 most likely schools, organizations, or doctors' offices that might have copies of the person's records? (e.g., past K-12 schools, doctors, service agencies, Medicaid, Social Security, etc.).			
1.	Name/Organization:		
	City:	State:	Phone:
2.	Name/Organization:		
	City:	State:	Phone:
3.	Name/Organization:		
	City:	State:	Phone:

To: The Department on Disability Services for the purposes of: determination of eligibility and planning for services to apply both now and in the future. This consent and release expires one year from the date of signing. Pursuant to the District of Columbia Mental Health Information Act of 1978, as amended (D.C. Official Code § 7-1201.01 et seq., specifically § 7-1202.01), the Citizens with Intellectual Disabilities Act, as amended (D.C. Official Code § 7-1301.01 et seq., specifically § 7-1305.12), the Health Insurance Portability and Accountability Act of 1996, as amended (Pub. L. No. 104-191), and other local and federal privacy acts, I voluntarily consent for the Department on Disability Services to obtain or release record information for the purposes stated above. I understand that this consent and release can be revoked by me in writing at any time. I understand that this information may not be redisclosed without my permission.

Signature

Check One: Person Requesting Services Legal Guardian Durable Power of Attorney

Name: _____ Signature: _____ Date: _____

Explained by (for office use)	
Agency Provider/Representative: _____	Date: _____
Title: _____	Phone: _____

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