



Intellectual Disabilities Services Request

Purpose: Request services and supports for adults with intellectual 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. We provide access to natural home supports, community resources, service coordination, state plan services, and services provided through the Home Community Based Services (HCBS) Waiver program.

You must meet ALL THREE requirements to receive services:

DC resident

Intellectual disability

Concurrent deficits in two areas of adaptive functioning

Submission Instructions

1. Complete this form

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

- Birth certificate or state ID
- Social security card
- Proof of DC residency (i.e. current lease or utility bill, official Social Security statement)

Collect the following documents (if available):

- Psychological evaluations documenting an intellectual disability
- Psychological evaluations documenting two adaptive functioning deficits
- Current physical or medical form from doctor

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

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

- **Email** (as a PDF attachment): dds-dda.intake@dc.gov
- **Mail:** Department on Disability Services; 250 E Street, SW, Washington, DC 20024
- **Bring in-person** to DDS: 250 E Street SW, Washington, DC 20024 | M-F, 8:15 am - 4:45 pm



Intellectual Disabilities Services Resquest 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/Caretaker

First Name:	Last Name:		
Relationship:	Email:	Phone:	
Address:	City:	State:	ZIP:

What services and supports are needed?

This information will help DDS begin a conversation with you about an appropriate service plan.

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Signature

The statements above are accurate to the best of my ability. I declare them to be true. Any significant changes in these circumstances will be made known immediately.

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

Name:	Signature:	Date:
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You'll be notified about your request in approximately 45 calendar days.

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:			



Consent to Obtain or Release Record Information

DDS may need additional information to develop an appropriate service plan. By completing this form you are allowing 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 *(check all that apply)*:

- | | | |
|--|--|---------------------------------|
| <input type="checkbox"/> Individual Educational Plan (IEP) | <input type="checkbox"/> Level of Need | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Behavior Support Plan (BSP) | <input type="checkbox"/> Psychological | |
| <input type="checkbox"/> Health Record | <input type="checkbox"/> Provider Documentation | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Health Care Management Plan | <input type="checkbox"/> Labs/Clinical/Health Data | |

Records disclosed by:

What are the 3 most likely schools, organizations, or doctors' offices that might have copies of the person's psychological evaluations? (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: Potential Residential Service Providers/Day Habilitation Service Providers; solely for the purpose of: consideration for determination of ability to provide Residential Services/Day Habilitation Services to apply both now and in the future. This consent 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 Mentally Retarded Citizens Constitutional Rights and Dignity Act of 1978 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. 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 purpose stated above. I understand that this consent can be revoked by me in writing at any time. I understand that this information may not be disclosed without my permission.

Signature

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

Name:	Signature:	Date:
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Explained by (for office use)

Agency Provider/Representative:	Date:
Title:	Phone:

