South Dakota Department of Human Services
Division of Developmental Disabilities Application for Services

Applicant Name:

Date of Birth: **Sex:**

Current Address:

Mailing Address (if different from current address):

Phone number: **Email Address:**

Preferred method of contact:

Preferred person to contact if not the applicant:

Phone number: **Email Address:**

First time applying? ☐ Yes ☐No ☐Unknown

Currently receiving Medicaid? ☐Yes ☐No **Currently receiving SSI/SSDI?** ☐Yes ☐No

Diagnosis: ☐Intellectual/Cognitive Disability ☐Autism ☐Down Syndrome
☐Cerebral Palsy ☐Other:

What are your strengths? What do people like about you?

What things do you like to do? How do you like to spend your day?

Why are you applying for services from DDD?

What supports do you need to be successful?

What is your primary way to communicate?

Written language?

What language do you best speak/or understand?

Do you need an interpreter/translator? ☐Yes ☐No

Daily Life and Employment

Education:

Are you currently in school? ☐Yes ☐No

If yes, which school:

School contact:

Are you on an IEP or 504 plan? ☐Yes ☐No

Do you have a signed diploma or a certificate of completion? ☐Yes ☐No

Do you have a GED? ☐Yes ☐No

Employment/Volunteering:

Are you currently working or volunteering? ☐Yes ☐No

If yes, where?

If no, are you interested in working? ☐Yes ☐No

Are you working in Vocational Rehabilitation? ☐Yes ☐No

Community Living

Do you currently live: ☐On your own ☐With Family ☐With Roommates

How much time do you typically spend alone each day?

Are you interested in receiving residential supports? ☐Yes ☐No

If yes: ☐Round-the-clock services ☐Daily residential supports ☐Residential supports as needed

Safety and Security

Legal Representative/Conservatorship – Check all that apply to the applicant if over 18 years old.

☐**No Legal Representative in place.**

☐**Court Ordered Legal Representative and type (medical, limited, etc.):_____**

☐**Court Ordered Conservator and Name if different from Legal Representative: _____**

☐**Power of Attorney and Type: _____**

Legal Representative's Name: _____
(First) (Middle) (Last)

Address: _____
(Street) (City) (State) (Zip)

Email Address: _____

Please attach copies of the Legal Documents

Are you currently incarcerated? ☐Yes ☐No

Have you ever been involved with the police? ☐Yes ☐No

If yes, have any of these issues resulted in a misdemeanor or felony charges? ☐Yes ☐No

Healthy Living

Do you use adaptive medical equipment? ☐Yes ☐No

If yes, please select below

☐Walking assistance (cane, walker, crutches) ☐Wheelchair ☐Adaptive bike or stroller

☐Standing devices ☐Mechanical Lifts ☐Orthotics ☐Specialized bed

☐Adaptive eating equipment ☐Other:_____

Are you currently taking any medications? ☐Yes ☐No

If yes, please attach a medication list.

Understanding your behavioral health needs allows us to ensure that the most appropriate services and supports are in place for you to be successful. Please describe this information to the best of your ability. Your application will still be considered by DDD if this section is not completed.

What is the behavior?	Describe the behavior	How often does it happen?	What supports help me be successful?
☐ Aggression towards others			
☐ Intentionally hurts self			
☐ Disruptive			

☐ **Sexual Concerns**			
☐ **Running away**			
☐ **Damaging property**			
☐ **Other**			

I would like you to contact me/my representative to discuss these behaviors in more detail:
☐Yes ☐No

What is currently working well in your life?	**What is not working? What is needed to improve?**

Have you ever received services from DDD? ☐Yes ☐No

If yes, when and what services did you receive:

Which DD waiver or program are you interested in receiving services from?

☐Family Support 360 ☐CHOICES ☐Strengthening Family

☐Respite Care ☐Community Training Services

What services or supports do you feel like you need to successful? ***Please reference the service descriptions outlined on pages 12 and 13 of the Application Guide for DD Services:***

I understand that for an individual to be eligible for Family Support 360 or CHOICES he/she must have a qualifying diagnosed developmental or intellectual disability.

SIGNATURE_____DATE_____

DEPARTMENT OF HUMAN SERVICES
Division of Developmental Disabilities

CHOICES Supplemental Information

If you are seeking services from the CHOICES waiver. Please include the following documentation (as applicable) attached with your application:

☐Medical history documentation

☐List of physicians/last examinations (please include dental and eye doctor examinations)

☐Immunization history

☐Documentation of any allergies

☐Additional behavior support information

☐Relevant legal history documentation

☐Nutritional information (i.e., specialized diet, swallow studies)