agency for persons with disabilities
State of Florida

Application for Services

Region/Field Office: _____ Phone #: _____

Name of APD Staff Person: _____Date of Application: ___/___/_____

1. Applicant Information

Name: _____ **SS#: *** _____

(Last) (First) (MI) (Suffix)

Address: _____ **Medicaid #**: _____

_____ **Phone #**: _____

Email: _____ **Alternate Phone #:** _____

DOB: _____ **Sex:** ____ **Race** (for data purposes only): ☐ White; ☐ Black; ☐ Asian; ☐ Native American or Alaskan Native; ☐ Other

Ethnicity (for data purposes only): ☐ USA; ☐ Cambodia; ☐ Cuba; ☐ Ethnic Chinese; ☐ Haiti; ☐ Laos; ☐ Mexico; ☐ Nicaragua; ☐ Poland; ☐ Puerto Rico; ☐ Russia; ☐ Vietnam; ☐ Other Hispanic Country; ☐ Other Asian Country; ☐ Other Foreign Country

Primary DD Diagnosis (must select at least one): ☐ Autism; ☐ Cerebral Palsy; ☐ Intellectual Disability; ☐ Prader-Willi Syndrome; ☐ Spina Bifida; ☐ Down Syndrome; ☐ Phelan McDermid Syndrome; OR, ☐ Between the ages of 3 and 5 and at High Risk of Developing a Developmental Disability (if selecting this box, please explain):_____

☐ **Secondary DD Diagnosis**: _____ ☐ **Mental Health Diagnosis**: _____

Do you have a job paying minimum wage or better? ☐ Yes ☐ No If No, are you interested in gainful employment? ☐ Yes ☐ No

1.a. Applicant's Primary Caregiver Information

Name: _____ **DOB:** _____

(Last) (First) (MI) (Suffix)

Phone #: _____ **Alternate Phone #:** _____

Relationship of Primary Caregiver to Applicant: _____

Does the primary caregiver have health issues that prevent them from continuing to provide care? ☐ Yes ☐ No If Yes, please indicate the medical issues: _____

Is the primary caregiver also providing primary care to a minor, elderly person or another person with a disability? ☐ Yes ☐ No If Yes, please explain: _____

Are the current caregiver responsibilities preventing them from being employed? ☐ Yes ☐ No

If the applicant is an adult (over the age of 18) has the applicant been removed from their family home by Adult Protective Services in the last 12 months? (Regardless of the result of the investigation) ☐ Yes ☐ No

2. Active Duty Military Service Member (if No to the first question, move to the next section)

Is the applicant's parent or legal guardian an active duty military service member? ☐ Yes ☐ No

If Yes, please identify by name: _____

Was the family transferred to FL as part of military assignment? ☐ Yes ☐ No

If Yes to the above, did the applicant receive home and community-based waiver services in another state? ☐ Yes ☐ No

If Yes to the above, please list services received: _____

Did the applicant move to FL to be closer to family while a parent or legal guardian is deployed? ☐ Yes ☐ No

If Yes, please explain: _____

Attached is a copy of the military service member's Uniformed Services ID Card ☐ Yes ☐ No

3. Person Assisting Applicant

Name: _____ Relationship to Applicant: _____

(Last) (First) (MI)

Address: _____

Phone #: _____ Alternate Phone #: _____

Email: _____ Preferred Language of Applicant/Legal Guardian: _____

4. Services Requested

I am requesting services via the Home and Community-Based Services (HCBS) Waiver. ☐ Yes ☐ No

OR

I am requesting services in an Intermediate Care Facility. ☐ Yes ☐ No

I am requesting the following services from the Agency for Persons with Disabilities:

_____ _____ _____

_____ _____ _____

_____ _____ _____

5. Applicant's Identity Verification (must check one) (to be filled out by APD Staff):

☐ FL Driver's License/ID Card ☐ US Passport ☐ Military/Government Issued Photo ID Card

☐ Certificate of Naturalization/Citizenship ☐ School Photo ID (only accepted for persons under the age of 16)

6. Applicant's Legal Status (select all that apply) (to be filled out by APD Staff)**:**

☐ Between the ages of 3 and 18 and under legal custody of his/her parent(s)

☐ Between the ages of 3 and 18 with a court appointed representative

☐ Between the ages of 3 and 18 and the parents have delegated decision making under the Family Care Act using a written power of attorney or durable power of attorney

☐ 18 or older and his/her own representative

☐ 18 or older and has delegated in writing decision-making authority related to governmental benefits or medical decisions to someone else by using a power of attorney or durable power of attorney

☐ 18 or older and a court has issued letters of guardianship or guardian advocacy, naming someone other than the applicant as the decision maker for governmental benefits or medical decisions

Name of legal guardian or guardian advocate, court appointed representative or person delegated decision making authority (if applicable):

_____

List type of document(s) provided as proof of legal status (if applicable): _____

7. Community Based Care (CBC) (if No to first question, move to next section) (to be filled out by APD Staff):

Is this applicant an active Community Based Care (CBC)/Child Welfare services recipient? ☐ YES ☐NO

If yes, Is he or she receiving out-of- home (foster care) services? ☐YES ☐NO

Is he or she receiving in-home (protective supervision) services? ☐YES ☐NO

8. Citizenship Verification (must check one) (to be filled out by APD Staff): :

To receive services from APD, the applicant and parent or legal guardian (if applicable) must be domiciled in Florida, and the applicant must be a U.S. citizen or resident alien

Is the applicant a U.S. Citizen? ☐YES ☐NO

Place of Birth: ☐United States (What State?) _____ ☐Other (Name of Country)_____

If not a US citizen, must provide USCIS alien status and number (also please fill out page 6 of this application):

☐Permanent Resident ☐Other:_____ USCIS #:_____

Type of documentation provided for proof of citizen or alien status:

☐US Birth Certificate ☐US Passport ☐Certificate of Naturalization/Citizenship ☐Green Card ☐ USCIS Issued Form

9. Residency:

Is the person requesting services a resident of the state of Florida? ☐YES ☐NO

If the applicant is a minor, is the parent or legal guardian domiciled in Florida? ☐YES ☐NO

Has the applicant recently relocated to Florida? ☐YES ☐NO

If YES, please explain _____

Residency Verification (must check one) (to be filled out by APD Staff):

☐FL Driver's License/ID Card; ☐Voter Registration Card; ☐FL Court Filed Declaration of Domicile; ☐Utility Bill; ☐Mortgage or Lease Agreement; ☐Employment/School Record

10. Eligibility Assessments:

Do you agree to participate in assessment(s) that may be needed to find out if you are eligible for services provided by APD?

☐YES ☐NO

Assessment Needed (to be filled out by APD Staff):

_____

_____

11. APD Eligibility Determination (to be filled out by APD Staff):

Eligible for APD: _____ Date: ___/___/_____

Eligibility Category: _____

Not eligible Date: ___/___/_____

Reason: _____

12. Collateral/Supporting Information or Source of Information About Disability (to be filled out by APD Staff):

(IQ scores, medical records, school records, etc.)

13. Waiver Eligibility Determination (to be filled out by APD Staff):	**14. ICF Eligibility Determination** (to be filled out by APD Staff):
Eligible for Medicaid Waiver: Date: ___/___/_____	Eligible for ICF: Date: ___/___/_____
Not eligible Date: ___/___/_____	Not eligible Date: ___/___/_____
Reason: _____	Reason: _____

15. By signing this application, I understand and acknowledge that it is my responsibility to keep the Agency informed of any changes in address or telephone number so that I may be contacted immediately if the Agency has any questions about my application, or, if I am deemed eligible for services if services have become available. Failure to keep the Agency informed of how I may be contacted may result in my application not being processed, or if determined eligible for services, my active client status being closed. Further, if my name has been added to the Medicaid HCBS Pre-Enrollment list, it will be removed. In the event the Agency is not able to contact me by mail or phone, I authorize the Agency to contact the following person, who does not live at my address:

ALTERNATE CONTACT:

Name: _____Phone: _____

Address:_____

Relationship to Applicant:_____ E-mail: _____

16. ALL INFORMATION PROVIDED ABOVE IS COMPLETE AND ACCURATE, TO THE BEST OF MY KNOWLEDGE.

Signature of Applicant: _____ Date: _____

Signature of Legal Representative: _____ Date: _____
For application for government benefits or for making medical decisions

Printed Name of Legal Representative: _____ Relationship: _____

Signature of Person Assisting the Applicant (if applicable): _____ Date: _____

17. Referrals (to be filled out by APD Staff):

To	Date	Contact	Address/Telephone #

I have received a copy of:

- ☐ The Bill of Rights of Persons who are Developmentally Disabled, section 393.13, Florida Statutes.
- ☐ Family Care Council Brochure
- ☐ Serving Floridians with Developmental Disabilities - brochure
- ☐ Agency for Persons with Disabilities Guide to Administrative Hearings- brochure
- ☐ HIPAA Notice of Privacy Practice

YOU CAN APPLY TO REGISTER TO VOTE HERE

If you are not registered to vote where you live now, would you like to register to vote here today? Check YES if you would like to apply to register to vote or update your voter registration information. If you check the NO box or do not

check a box, you will be considered to have decided not to apply to register to vote or update your voter registration information. Checking YES, NO, or leaving this question blank will not affect your receipt of benefits.

☐ **YES** ☐ **NO**

NOTICE OF RIGHTS

Help: If you would like help in filling out your voter registration application, we will help you. The decision whether to seek or accept help is yours. You may fill out the voter registration application in private.

Benefits: If you are applying for public assistance from this agency, applying to register, or declining to register to vote will not affect the amount of assistance you will be provided by this agency.

Privacy: Your decision not to register or update your record and the location where you applied to register or update your voter registration record is confidential and may only be used for voter registration purposes.

Formal Complaint: If you believe someone has interfered with either your right to apply to register or to decline to register to vote, your right to privacy in deciding whether to apply to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with: Florida Secretary of State, Division of Elections, NVRA Administrator, R.A. Gray Building, 500 S. Bronough Street, Tallahassee, Florida 32399-0250. Forms for filing a complaint are available at http://election.dos.state.fl.us/nvra/index.shtml

*** Federal law requires the collection of your social security number as a condition of eligibility for Medicaid benefits under 42 U.S.C. 1320b-7 and the agency will collect, use, and release the number for administrative purposes as authorized under law.**

FILL-IN INFORMATION REQUIRED FOR VERIFICATION OF NON USA BORN CITIZENS/IMMIGRANTS

DOCUMENT TYPE	ALIEN/ USCIS/INS NUMBER "A" followed by 7,8, OR 9 numbers	CARD NUMBER 3 letters followed by 10 numbers Ex. ABC0000000000	I-94 NUMBER 11 digit number Ex. 000 00000000	PASSPORT NUMBER 6 to 12 digits with alpha-numeric characters	EXPIRE DATE	COUNTRY OF ISSUANCE	CERTIFICATE NUMBER 8 digit number Ex. 00 000 000	SEVIS ID "N" followed by 10 digit number Ex. N0000000000	NAME OF DOCUMENT
I-551 (Permanent Resident Card)									
Certificate of Citizenship									
Naturalization Certificate									
Unexpired Foreign Passport									
I-571 (Refugee Travel Document)									
DS2019 (Certificate of Eligibility for Exchange Visitor (J-1) Status)									
I-20 (Certificate of Eligibility for Nonimmigrant (F-1) Student Status)									
I-327 (Reentry Permit)									
I-766 (Employment Authorization Card)									
I-94 (Arrival/Departure Record)									
I-94 (Arrival/Departure Record) in Unexpired Foreign Passport									
Machine Readable Immigrant Visa (with Temporary I-551 Language)									
Temporary I-551 Stamp (on passport or I-94)									
Other (Select If Document Not Listed)									