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| 1. **Applicant Information**   **Legal First Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Legal Last Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Legal Middle Initial:** \_\_\_\_\_\_ **Suffix:** \_\_\_\_\_\_\_\_ **Date Of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Sex (circle one):** Male or Female  **Social Security Number: \_\_\_\_\_\_ - \_\_\_\_ - \_\_\_\_\_\_ Medicaid ID # (if known)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Race** (for data purposes only):  White   Black   Asian   Native American or Alaskan Native  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Mother’s Maiden Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Mother’s Maiden First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Select at least one Developmental Disability Diagnosis for eligibility consideration:**   Autism   Cerebral Palsy   Intellectual Disability  Prader-Willi Syndrome  ☐ Spina Bifida ☐ Down Syndrome   Phelan McDermid Syndrome  Between the ages of 3 and 5 and at High Risk of Developing a Developmental Disability (If selecting this box, please explain):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (Please see Quick Guide: Applying for APD Services to utilize as a reference for proof of diagnosis documentation.)  **Other Diagnosis (if applicable)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Applicant’s Contact Information:**  **Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **City:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State:** \_\_\_\_\_\_\_\_\_\_\_ **Zip Code:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **County:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Phone #**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Email:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Preferred Method of Communication:** \_\_\_\_\_\_\_\_\_ **Phone** or \_\_\_\_\_\_\_\_\_ **Email**  **Preferred Language:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    **Applicant’s Legal Representative:** Please complete the information if the applicant has a legal representative. **(***For applicants under 18, this includes the parent, health care surrogate, or anyone designated by the parent(s) of the child to act on the parent(s)’ behalf. For applicants 18 and over, this could include the applicant, anyone designated by the applicant through a Power of Attorney or Durable Power of Attorney, a medical proxy under Chapter 765, F.S., or anyone appointed by a Florida court as a guardian or guardian advocate under Chapter 393 or 744, F.S.)* Please proceed to Household Information section if applicant doesn’t have a Legal Representative.  **Legal Rep. First Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Legal Rep. Last Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Legal Rep. Middle Initial:** \_\_\_\_\_\_ **Suffix:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Type of Legal Representative:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Phone #**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Email:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Preferred Method of Communication:** \_\_\_\_\_\_\_\_\_ **Phone** or \_\_\_\_\_\_\_\_\_ **Email**   1. **Household Information:** (Please complete this section if the applicant has a primary caregiver.)   **Primary Caregiver’s Legal First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Legal Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Caregiver’s Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Does the primary caregiver have health issues that prevent them from continuing to provide care?** Yes or  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 or  No  **If Yes, please explain**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Are the current caregiver responsibilities preventing them from being employed?**  Yes or  No  **Does the applicant have a sibling with a developmental disability?**  Yes or  No |
| 1. **Active Duty Military Service Member** (if No to the first question, move to section 4.)   **Is the applicant’s parent or legal guardian an active-duty military service member?**  Yes or  No  **If Yes, please identify by name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Was the family transferred to FL as part of military assignment?**  Yes or  No  **If Yes, did the applicant receive home and community-based waiver services in another state?**   Yes or  No |
| 1. **Residency**   **Is the applicant a permanent resident of the State of Florida?**  Yes or  No  **If the applicant is a minor, is the parent or legal guardian domiciled in Florida?**  Yes or  No  In many instances, APD can verify Florida residency or citizenship for applicants through information provided on this application form. If necessary, APD may request additional information or documentation to verify residency or citizenship in order to complete your application. |
| 1. **Eligibility Assessments**   **If necessary, do you agree to participate in clinical assessments that may be needed to determine eligibility for APD?**  Yes or  No |
| 1. **I have received a copy of:**   HIPAA Notice of Privacy Practices  Consent to Obtain or Release Protected Health Information |
| 1. **Voter Registration: YOU CAN APPLY TO REGISTER TO VOTE** [**HERE**](https://dos.fl.gov/elections/forms-publications/forms/) **(Form DS-DE-77):**   See “National Voter Registration Act Preference Form/Application” (Department of State Form DS-DE 77), incorporated by reference in Rule 1S-2.048, *Florida Administrative Code*. |
| 1. **CERTIFICATION AND SIGNATURE**   **By signing this application, I understand, acknowledge, and certify, under the penalties of perjury, the following:**   * That all information provided is complete and accurate. * That it is my responsibility to keep the Agency informed of any changes in address, email, or phone number and failure to do so may result in my application not being processed or case closure. * That knowingly providing false representations constitutes an act of fraud. False, misleading, or incomplete information may result in the denial of my application. * That additional information and/or documentation related to my application may be requested at any time.   **Signature of Applicant:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Signature of Legal Representative** (if applicable)**:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Name of Person Assisting Applicant with Application** (if applicable)**:**  **Printed First & Last Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Relationship to Applicant:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Signature of Person Assisting the Applicant:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**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 purpose as authorized under law.**