agency for persons with disabilities
State of Florida

Application for Services

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**

2. 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

3. 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

4. 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.

5. Eligibility Assessments

If necessary, do you agree to participate in clinical assessments that may be needed to determine eligibility for APD?

☐ Yes or ☐ No

6. I have received a copy of:

☐ HIPAA Notice of Privacy Practices

☐ Consent to Obtain or Release Protected Health Information

7. Voter Registration: YOU CAN APPLY TO REGISTER TO VOTE HERE (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*.

8. 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.