Developmental Disabilities Services

Georgia Department of Behavior Health and
DEVELOPMENTAL DISABILITIES

APPLICATION FOR DEVELOPMENTAL DISABILITIES/
INTELLECTUAL DISABILITIES SERVICES

IF YOU NEED ASSISTANCE COMPLETING THIS APPLICATION, PLEASE CONTACT THE LOCAL INTAKE AND EVALUATION OFFICE BY CONTACTING: Region 1 Field Office 1230 Bald Ridge Marina Rd, Suite 800, Cumming GA 30041 678-947-2818

I. GENERAL INFORMATION (APPLICANT)

Name: _____
First Middle Last

Address: _____
Street Address (Apartment Number if Applicable)

_____
City County State Zip Code

Mailing Address (if different) _____

Telephone Number: _____ Marital Status: S M D W Sex: _____
Area Code

Birthdate: _____ /_____ /_____ Medicare # _____

Social Security # _____-_____-_____ Medicaid #_____

PRIMARY CONTACT: _____

Address: _____

_____
City County State Zip Code

Relationship to Applicant: _____ Telephone Number: _____
Area Code

Email: _____

LEGAL STATUS OF APPLICANT: ___Minor ___Competent ___Legally Incompetent (Documentation Required)

Name of Legal guardian, if applicable: _____

Address: _____
Street Address (Apartment Number if Applicable)

_____
City County State Zip Code

Relationship to Applicant: _____ Telephone Number: _____
Area Code

Email: _____

II. ASSESSMENT OF DEVELOPMENTAL DISABILITY AND ELIGIBILITY

To be eligible for Georgia's Developmental Disabilities services, you must be:

a. Medicaid eligible
b. Have Intellectual Disability since birth or before age 18, or another developmental disability since birth or before age 22, which requires similar services to those needed by people with an Intellectual Disability.
c. Be at risk for going into an institution for people with an Intellectual Disability, if you do not get the services you need in your community.

During your initial screening appointment, specific medical information will be collected to confirm the disability. Please read the *Information for Applicant* checklist at the front of this application, and send items and/or copies along with your application.

III. SERVICE NEEDS

Describe the type of services you believe you need. For example do you need help with getting a job, do you need assistance to get dressed, do you need family support or do you need some place to live.

_____

_____

_____

_____

_____

IV. COMPLETED BY:

Name: _____ Date: _____

Relationship: ____Applicant ____Guardian ____Other: _____

Printed Name: _____

What is the best way to contact you?

_____

When this application is received, it will be stamped with a date. Once all requested documentation is received, it will be reviewed and if it is determined to be a complete application packet a screening appointment will occur within 14 days. If further information is needed someone from our office will be in touch. If this does not occur, please call the Intake and Evaluation listed above.