# APPLICATION FOR SERVICES
# DEVELOPMENTAL DISABILITIES SERVICES

Cedar Ridge ICF/MR
P.O. Box 2389
Alma, AR 72921

**INSTRUCTION: Please print, Fill out this form on both sides to the best of your knowledge. You may wish the help of your public health nurse. Welfare Office, or family doctor. If you do not know an answer, leave that blank. Mail this form to the above address.**

Date: _____

GENERAL INFORMATION ABOUT THE DISABLED PERSON:

NAME: (Last) _____ (First) _____ (Middle) _____

Address: _____ Town: _____ State: _____ Zip: _____

Home Telephone Number: ___-_____ Birthday: ___-___-___

County: _____ Medicaid #: _____-_____ Social Security #: ___-___-___

Sex: _____ Race: _____ Height: _____ Weight: _____

Referred to DDS by: _____

MAJOR DISABILITIES: (Check as many as apply)

Mental Retardation _____ Eplipesy _____ Cerebral Palsy _____

Other (Specify) _____

DESCRIPTION OF ABILITIES: (Check most appropriate blanks)

| | GOOD | FAIR | POOR | NO | | COMPLETELY | PARTIALLY | NOT AT ALL |
|---|---|---|---|---|---|---|---|---|
| WALK | ___ | ___ | ___ | ___ | FEED SELF | _____ | _____ | _____ |
| TALK | ___ | ___ | ___ | ___ | DRESS SELF | _____ | _____ | _____ |
| SEE | ___ | ___ | ___ | ___ | TOILET TRAINED | _____ | _____ | _____ |
| GENERAL HEALTH | ___ | ___ | ___ | ___ | | | | |
| HEAR | ___ | ___ | ___ | ___ | | | | |

NEEDS THE FOLLOWING SPECIAL EQUIPMENT: GLASSES _____ CRUTCHES _____ BRACES _____

WHEELCHAIR _____ HEARING AID _____ OTHER (SPECIFY) _____

INDICATE THE YEAR(s) IN WHICH SERVICES WERE RECEIVED FROM ANY OF THE FOLLOWING:

SOCIAL SERVICES _____ RESIDENTIAL INSTITUTIONS _____

CRIPPLED CHILDRENS SERVICE _____ MENTAL HEALTH CENTER _____

SPECIAL EDUCATION _____ REHABILITATION SERVICES _____

REGULAR SCHOOL CLASSES _____ NURSING HOME _____

SHELTERED WORKSHOP _____ OTHER _____

DAY SERVICE CENTER _____ _____

What is the approximate Mental Age or IQ of this person? (If psychological test scores are known, type of test, where testing was done, and date tested.) _____

_____

Does the disabled person have behavior problems? Yes _____ No _____ If yes, describe

_____

_____

Please attach a list with addresses of all doctors, hospitals/clinics, schools, training facilities, etc, that have provided services to the disabled person.

APPLICATION IS MADE FOR THE FOLLOWING SERVICE (s)

Diagnosos and Evaluation _____ Human Development Center _____

Day Care _____ Human Development Center Respite _____

Job Training _____ Group Home Placement _____

Family Counseling _____ Family Care & Training Home Placement _____

Specialized Counseling _____ Other (Explain) _____

PARENTS OF DISABLED INDIVIDUAL:

MOTHER'S NAME: (LAST) _____ FIRST _____ MIDDLE _____

Mothers Address _____ Town _____ State _____

County _____ Home Phone _____ Business Phone _____

Social Security Number: ___ - ___ - ___ Length of Ark. Residency* _____

FATHER'S NAME: (LAST) _____ FIRST _____ MIDDLE _____

Fathers Address _____ Town _____ State _____

County _____ Home Phone _____ Business Phone _____

Social Security Number: ___ - ___ - ___ Length of Ark. Residency* _____

Guardian (If other than Parent):Last _____ First _____ Middle _____

Guardian or Custodian's Address: _____ Town _____ State _____

Home Phone: _____ Business Phone _____ County _____

Social Security # _____ Length of Arkansas Residency _____

Total Number of Family Members in the Household _____

Family Take Home Income Per Month _____

Source of Income: Wages: _____ AFDC: _____ SSI _____ VA _____ OTHER _____

PERSON FILLING OUT THIS APPLICATION:

NAME:(Last) _____ (First) _____ (Middle) _____

Address: _____ Town: _____ State: _____

AGENCY NAME OR RELATIONSHIP TO CLIENT: _____

As part of this Application for Services, I hereby authorize the release and/or exchange of professional information

on behalf of _____ BETWEEN Arkansas Mental Retardation-Developmental

Disabilities Service and any public and/or private professional agency and/or individual having professional contact with said child and/or his/her family.

_____ _____

DATE (PARENT OR GUARDIAN)Disabled must sign if over 18 and own LEGAL Guardian.

_____

WITNESS

NOTICE: If you would like to add further comments or explanations please attach a separate sheet of paper.

Mental Retardation Developmental Disabilities Services is in compliance with TitleVI of the Civil Rights Act and is operated, managed its services without regard to race, color or national origin.