



OKLAHOMA DEPARTMENT OF HUMAN SERVICES



Request for Developmental Disabilities Services

Date		Cor	unty			OKDHS ca	se number			
This form is used to apply for services to persons with developmental disabilities through OKDHS Developmental Disabilities Services Division (DDSD). This application does not address financial eligibility requirements for Medicaid funded DDSD services. Section 1. Applicant										
Applicant legal last name First				Mi	ddle	Area code	Home phone			
Street addre	Street address City					State	Zip			
Also known as				Date	of birth	Gender Male Female				
Race	ce Area code Home phone				Social Security number, attach copy of card					
United States citizen Yes No Marital status:				Resident alien Yes No Language spoken or understood by applicant						
Married Single Divorced Widowed										
Applicant employed Yes No				If yes, employer:						
Completed by state employee										
Who has legal custody?				County of adjudication Adjudication date						
Primary wor	Primary worker				Supervisor	Area code	Work phone			
If OKDHS or Office of Juvenile Affairs (OJA) has legal custody, attach copy of order. Type: Temporary Permanent										

Section 2. Parents/guardian

Father	Area code	Home ph	one	Area code		Work phone
Street address	City		State		Zip	
Mother	Area code Home pho		one Are		ea code	Work phone
Street address	City		Stat	e Zip		
Legal guardian	Area code	Home phone Ar		ea code	Work phone	
Street address	City		State Z		Zip	
Primary correspondent, if different				Relation	ship	
Street address, if different	City		State		Zip	
Secondary correspondent		Relationsh			ship	
Street address	City		State		Zip	

Section 3. Household members

Name	Relationship	Date of birth	Occupation	Health status

Section 4. Medical

Attach copy of applicant's birth certificate.

Hospital or facility where applicant was born								
Street address	reet address (City	State Zip		Zip		
Briefly descril	be any	v significant m	nedical pr	oblems/disab	ilities exp	perienced	d by app	olicant.
 2. Who is applicant's current primary care physician? 3. Does applicant take any routine medication? If yes, list medication, dosage, and reason for medication. 							No 🗌	
4. Has applicant been diagnosed with mental retardation, autism, or mental illness? Yes \(\scale \) No \(\scale \)							No 🗌	
If yes, list diagno	yes, list diagnosis When			By whom				
5. Has applicant had a psychological evaluation? Attach copy, if available. Yes No							No 🗌	
If yes, when	Wher	·e		By whom		I.Q.	Menta	al age
Describe any be								
Section 5. Education Is applicant currently attending school? Yes No							No 🗀	
If yes, where			1	Special class		ar class	Grade	
Copy of applican		rent individua	alized edu	ıcation plan (II	EP) avai	lable? Y	es 🗌	No 🗌

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If out of school, where did applicant attend school? Briefly describe applicant's adjustment to school regarding peer interaction and relationships with teachers.						
Section 6. Additional information						
Services currently receiving from the school, community, and other agencies:						
Check all that apply. Currently receiving: Supplemental Security Income (SSI) Social Security Administration (SSA) payment Medicaid Medicare						
Requested DDSD services:						
 Home and Community-Based Services (HCBS) eligibility for state-funded group home/assisted living without waiver supports state-funded workshop/community integrated employment 						
What kind of help do you need?						
I authorize OKDHS to make this application available for evaluation services to agencies designated by OKDHS. I further agree to comply with all applicable laws, rules, and regulations, and understand that services and benefits for persons with developmental disabilities are equally available to all persons without regard to race, color, religion, or national origin. I understand that I may cancel or withdraw this application for services by submitting written request to the appropriate DDSD area office.						
The information in this application is correct to the best of my knowledge:						
Legally responsible party/applicant signature Date						
If applicant is age 18 or older and does not have a legal guardian:						
Person assisting applicant signature Date						
OKDHS action regarding this application must occur within 180 days from the date of receipt by OKDHS of the completed application. When state DDSD resources are						

unavailable to serve new applicants in the HCBS program, they are placed on a statewide waiting list.

Return to DDSD office in the area where applicant resides.

DDSD Area I Office

729 Overland Trail Enid, OK 73703

Toll free: 1-800-522-1064; and

DDSD Area I Office

2401 NW 23rd Street, Suite 28 Oklahoma City, OK 73107-2442

Toll free: 1-800-522-1064

Covers: Alfalfa, Beaver, Blaine, Canadian, Cimarron, Custer, Dewey, Ellis, Garfield, Grant, Harper, Kay, Kingfisher, Lincoln, Logan, Major, Noble, Oklahoma, Payne, Roger Mills, Texas, Woods, and Woodward

DDSD Area II Office

1427 East 8th Tulsa, OK 74120

Toll free: 1-800-522-1075

Covers: Adair, Cherokee, Craig, Creek, Delaware, Mayes, McIntosh, Muskogee, Nowata, Okfuskee, Okmulgee, Osage, Ottawa, Pawnee, Rogers, Sequoyah, Tulsa, Wagoner, and Washington

DDSD Area III Office

301 South Indian Meridian Road Pauls Valley, OK 73075

Toll free: 1-800-522-1086

Covers: Atoka, Beckham, Bryan, Caddo, Carter, Choctaw, Cleveland, Coal, Comanche, Cotton, Garvin, Grady, Greer, Harmon, Haskell, Hughes, Jackson, Jefferson, Johnston, Kiowa, Latimer, LeFlore, Love, Marshall, McClain, McCurtain, Murray, Pittsburg, Pontotoc, Pottawatomie, Pushmataha, Seminole, Stephens, Tillman, and Washita

