agency for persons with disabilities
State of Florida

Application for Services

Grey areas are for completion by APD office staff only.

Area Office: _____ Phone #: _____

Name of APD Staff Person: _____ Date of Application: _____

1. Services Requested

I am requesting the following services from the Agency for Persons with Disabilities:

_____

_____

I am requesting participation in either the Family and Supported Living or the Developmental Disabilities Home and Community-Based Services Waivers. ☐ Yes ☐ No

OR

I am requesting to be served in an intermediate care facility.

☐ Yes ☐ No

2. Person for Whom Support and Services Are Requested

Name: _____
(Last) (first) (MI) (Suffix)

SS#: * _____

Medicaid #: _____

Address: _____

_____

Phone #: _____

Alternate Phone #: _____

Email: _____

DOB: _____ Sex: _____

Legal Status: _____
(see instructions)

Preferred Language of Applicant/Guardian: _____

3. Person Assisting Applicant

Name: _____
(Last) (first) (MI)

Relationship to Applicant: _____

Address: _____

_____

Phone #: _____

Alternate Phone #: _____

Email: _____

Is this person an active Community Based Care (CBC)/Child Welfare services recipient? ☐ YES ☐ NO

If Yes:

Is he or she receiving out-of- home (foster care) services?

☐ YES ☐ NO

Is he or she receiving in-home (protective supervision) services?

☐ YES ☐ NO

4. Residency: Please check all that apply:

☐ Florida Resident ☐ US Citizen ☐ Resident Alien

Place of Birth: _____
(state) country)

To receive services from APD, the applicant must be domiciled in Florida, and be a U.S. citizen or resident alien.

Type of documentation provided to show residency and ID (birth certificate, Green Card, driver's license, school photo ID, etc.):

_____

5. Eligibility Assessments:

I agree to participate in assessment(s) that may be needed to find out if I am eligible for services provided by APD.

☐ Yes ☐ No

Assessments Needed: _____

_____

_____

_____

_____

FORM TITLE: APPLICATION FOR SERVICES, RULE 65G-4.016 | **YEAR:** 2007 | **FORM NUMBER:** 10-007

Name: _____
(Last (First) (MI) (Suffix)

SS#: *_____

6. APD Eligibility Determination	7. Collateral/Supporting Information or Source of Information About Disability
Eligible for APD: _____ Date: ___/___/_____ Eligibility Category: _____ Not eligible Date: ___/___/_____ Reason: _____	*(IQ scores, medical records, school records, etc.)*
8a. Waiver Eligibility Determination	8b. ICF Eligibility Determination
Eligible for Medicaid Waiver: Date: ___/___/_____ Not eligible Date: ___/___/_____ Reason: _____	Eligible for ICF: Date: ___/___/_____ Not eligible Date: ___/___/_____ Reason: _____

9. By signing this application, I understand and acknowledge that it is my responsibility to keep the Agency informed of any changes in address or telephone number so that I may be contacted immediately if the Agency has any questions about my application, or, if I am deemed eligible for services if services have become available. Failure to keep the Agency informed of how I may be contacted may result in my application not being processed, or if determined eligible for services, my active client status being closed. Further, if my name has been added to the Medicaid HCBS Waiver Wait list, it will be removed. In the event the Agency is not able to contact me by mail or phone, I authorize the Agency to contact the following person, who does not live at my address:

ALTERNATE CONTACT:

Name: _____Phone: _____

Address:_____

Relationship to Applicant:_____ E-mail: _____

10. ALL INFORMATION PROVIDED ABOVE IS COMPLETE AND ACCURATE, TO THE BEST OF MY KNOWLEDGE.

Signature of Applicant: _____ Date: _____

Signature of Legal Representative: _____ Date: _____
For application for government benefits or for making medical decisions

Printed Name of Legal Representative: _____ Relationship: _____

Signature of Person Assisting the Applicant (if applicable): _____ Date: _____

Name:_____
(Last (First) (MI) (Suffix)

SS#: *_____

11. .Referrals

To	Date	Contact	Address/Telephone #

I have received a copy of:

- ☐ The Bill of Rights of Persons who are Developmentally Disabled, section 393.13, Florida Statutes.
- ☐ Family Care Council Brochure
- ☐ Serving Floridians with Developmental Disabilities - brochure
- ☐ Agency for Persons with Disabilities Guide to Administrative Hearings- brochure
- ☐ Right to Privacy – brochure

* The collection of social security number is for record keeping purposes and is imperative to the agency's duties and responsibilities as prescribed by law. The social security number collected will not be available to the general public.