APPLICATION CHECKLIST

Thank you for your interest in DDA-funded support services provided by The Arc Montgomery County.

To be eligible for these services, an applicant must be approved for the *DDA Community Pathways Medicaid Waiver*. For information on how to apply for the DDA Community Pathways Medicaid Waiver, Please see these pages on the DDA Website: *DDA Eligibility Application* and *DDA Waiver Application Process*.

The Arc Montgomery County provides support services to people who are using the Traditional Service Model and not the Self-Directed Service Model *at this time*.

The following documents will need to be submitted with the application:

- Application for DDA-Funded Support Services (following pages)
- Copy of most recent IP/PCP, whichever is applicable
- Copy of most recent Psychological Evaluation
- Copy of most recent Health Risk Screening Tool (HRST)
- Copy of Birth Certificate
- Copy of Maryland State ID Card or Driver's License
- Copy of Medicaid Card
- Copy of Medicare Card (if applicant receives Medicare)
- Copy of Social Security Card
- Copy of document that shows proof of Social Security Income (SSI or SSDI)
- Copy of document that shows the name of the person who is the Representative Payee for Social Security Income (SSI or SSDI)
- Copy of relevant guardianship or power of attorney legal documents (if applicable)
- Copy of Behavior Plan, if applicable
- *OPTIONAL DOCUMENT*: *Copy of reports on relevant medical history.*

Once we have reviewed your information, we will call you to schedule an interview, or if we are not able to meet your needs, we will refer you to another provider.

Thank you and we look forward to hearing from you soon!

If you have questions about our programs, please first contact the Information & Resource Navigator at *Info@TheArcMoCo.org* and at 301.984.5777 x1263. You may also contact one of the Adult Services Program Directors:

Employment & Meaningful Day Services
Kelli Hunter-Bennett, *Employment@TheArcMoCo.org*, *MeaningfulDay@TheArcMoCo.org*

Community Living Services
Kari Borgealt, *CommunityLiving@TheArcMoCo.org*

Personal Supports
Adam McArthur, *PersonalSupports@TheArcMoCo.org*

APPLICATION FOR DDA-FUNDED SUPPORT SERVICES

Please indicate area(s) of Interest below. The Arc Montgomery County is a DDA-approved provider for all of these support services.

Employment Services Job Development Kelli Hunter-Bennett, *Employment@TheArcMoCo.org*

- ☐ Career Exploration
- ☐ Employment Discovery and Customization
- ☐ Follow Along Supports
- ☐ Job Development
- ☐ Ongoing Job Supports
- ☐ Supported Employment

Meaningful Day Services Kelli Hunter-Bennett, *MeaningfulDay@TheArcMoCo.org*

☐ Community Development Services (to include volunteering, leisure/recreational activities, and social senior activities)

☐ Volunteering ☐ Leisure/Recreation Activities ☐ Social Senior Activities

Community Living Services Kari Borgealt, *CommunityLiving@TheArcMoCo.org*

- ☐ Community Living (full residential support)
- ☐ Supported Living (residential support for those in their own home)

Personal Supports Adam McArthur *PersonalSupports@TheArcMoCo.org*

☐ Personal Supports (community inclusion, in-home skill building,)

Applicant Information (about the person who will receive support services)

Name: _____
First *Middle* *Last*

Street Address: _____

City: _____ State: _____ Zip: _____

List and describe all pets in the home: _____

For people seeking Employment, Meaningful Day, or Personal Supports, list other people residing in the same household as Applicant.

First Name	Last Name	Relationship	Age

Email: _____ Phone: _____

Date of Birth: _____/_____/_____ (MM/DD/YYYY) Social Security Number: _____

Gender Identification: _____ Preferred Pronouns: _____
(male, female, gender neutral, etc.) *(he/him/his, she/her/hers, they/them/theirs, etc.)*

Preferred method of communication: ☐ Email ☐ Phone ☐ Text Message

Race *(check all that apply)*: ☐ White ☐ Black/African American ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian or Pacific Islander ☐ Other _____

Ethnicity: ☐ Non-Hispanic or Latino ☐ Hispanic or Latino

Primary Language Spoken in Home: _____

Language(s) Understood by Applicant: _____

How Applicant Communicates (verbally, sign language, gestures, assistive device, etc.):

_____

Accommodations: ☐ Interpreter ☐ Vision/Hearing ☐ Translator ☐ Other _____

Applicant benefits received: ☐ Medicaid ☐ Medicare ☐ Social Security

*Is the applicant approved for and/or accessing the Community Pathways Waiver at this time?**

**Note that all people who were approved for and/or accessing the Family Supports Waiver or the Community Supports Waiver were moved to the Community Pathways Waiver effective October 6, 2025. After that date, all people on a DDA Medicaid Waiver are on the Community Pathways Waiver.*

Guardian/Power of Attorney Information (if applicable)

Name: _____ Title: _____
First *Last*

Street Address: _____

City: _____ State: _____ Zip: _____

Email: _____ Phone: _____

Preferred Pronouns: _____
(he/him/his, she/her/hers, they/them/theirs, etc.)

Preferred method of communication: ☐ Email ☐ Phone ☐ Text Message

Accommodations: ☐ Interpreter ☐ Translator; Language: _____

☐ Vision/Hearing ☐ Other _____

Applicant Medical Information

Primary Disability: _____

Cause of Disability (if applicable): _____

When Diagnosed: _____ By Whom: _____

Primary Physician: _____ Phone: _____

Medical Assistance (Medicaid) Number: _____ Medicare Number: _____

Private Insurance Company (if applicable): _____

Private Insurance Identification Number: _____

Check all that apply and provide explanations as necessary.

☐ Allergies ☐ Dietary Needs/Restrictions ☐ Diabetes

☐ Seizures ☐ Work Restrictions ☐ Physical Disability

☐ Hearing Impairment ☐ Vision Impairment ☐ Speech Impairment

☐ Psychiatric Diagnosis ☐ Sun Sensitivity ☐ Adaptive Equipment

☐ Choking/Aspiration ☐ Other (please specify)

Please provide explanations of the conditions checked above, and please add summary information on other pertinent medical history. In addition, please submit any medical documents or reports that you feel would provide additional information on your medical history. (use additional paper if needed):

Provide the following information about all medications taken by Applicant or please provide a doctor-provided list of all medications taken by Applicant. Be sure that the doctor-provided list includes all of the information requested in the table below. If completing application by hand, please attach paperwork if additional medication is taken as necessary

Applicant Behavior Information

Behaviors of Concern

A behavior of concern is one that affects quality of life, inflicts harm on others or oneself, or affects participation in our program. Certain behaviors may not be dangerous or life threatening, but are ones about which we should be aware (i.e. fear of animals, loud noises, etc.). In order to provide the best possible services, it is important for us to know as much about you as possible.

Medication Name	*Dose/Time*	*Reason Taken*	*Administration*
			☐ Self ☐ Others
			☐ Self ☐ Others
			☐ Self ☐ Others
			☐ Self ☐ Others
			☐ Self ☐ Others
			☐ Self ☐ Others

Does Applicant have a Behavior Support Plan? ☐ Yes ☐ No

Describe Behaviors of Concern:

Supervision Requirements

Please mark which description best reflects Applicant's needs.

☐	☐	☐	☐	☐	☐	☐
I need ongoing supervision and cannot be left without line of sight supervision.	I need supervision when involved in a structured setting.	I need occasional supervision in a structured setting.	I need little supervision if expectations and boundaries are defined.	I require 1:1 medical support.	I require 1:1 behavioral support.	I do not need supervision.

Is Applicant able to safely spend time at home, alone and unsupervised? ☐ Yes ☐ No

If yes, for how long? _____

Travel and Transportation

Please mark which description best reflects Applicant's travel method.

☐	☐	☐	☐	☐
I do not independently access transportation and need support while on board a vehicle.	I need door-to-door transportation.	I have Metro Access.	I use Metro Access. #_____	I use public transportation (with or without travel training).

Applicant Program Information

Describe other programs or activities in which Applicant participates now or has previously participated (include school, day programs, residential programs, and previous employment).

Program/Activity/Employment	*Contact Person*	*Contact Phone*	*Dates Attended*	*Why Left?*

Applicant Financial Information

Please provide the following information about all financial support Applicant receives.

For people seeking employment services: Are you eligible to work in the United States? ☐ Yes ☐ No

Family Contact Information (about parents/guardians/siblings currently supporting Applicant)

Primary Contact (if different from Guardian/POA)

Name: _____
First *Last*

Relationship: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Email: _____ Phone: _____

Preferred method of communication: ☐ Email ☐ Phone ☐ Text Message

Accommodations: ☐ Interpreter ☐ Translator; Language: _____

☐ Vision/Hearing ☐ Other _____

Secondary Contact

Name: _____
First *Last*

Relationship: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Email: _____ Phone: _____

Preferred method of communication: ☐ Email ☐ Phone ☐ Text Message

Accommodations: ☐ Interpreter ☐ Translator; Language: _____

☐ Vision/Hearing ☐ Other _____

Did Applicant receive assistance completing this application? ☐ Yes ☐ No

If yes, who assisted Applicant? _____

Applicant's Coordinator of Community Services (CCS)

Please provide the name and contact information of applicant's CCS below:

	Received?	*If yes, please provide monthly amount*
SSI (Social Security Income)	☐ Yes ☐ No	
SSDI (Social Security Disability Income)	☐ Yes ☐ No	
Other (describe)	☐ Yes ☐ No	
Other (describe)	☐ Yes ☐ No	
Other (describe)	☐ Yes ☐ No	

Name: _____

Email: _____ Phone: _____

Checklist of Additional Documents to Submit with Application:

Please check off each additional document we require with the application. If you are not submitting one of these documents, please provide a brief explanation of the reason for not submitting the document in the space provided after the list.

☐ Please check off all that are being submitted with application:

☐ Copy of most recent IP/PCP, whichever is applicable.

☐ Copy of most recent Psychological Evaluation

☐ Copy of most Health Risk Screening Tool (HRST)

☐ Copy of Birth Certificate

☐ Copy of Maryland State ID Card or Driver's License

☐ Copy of Medicaid Card

☐ Copy of Medicare Card (if applicant receives Medicare)

☐ Copy of Social Security Card

☐ Copy of document that shows proof of Social Security Income (SSI or SSDI)

☐ Copy of document that shows the name of the person who is the Representative Payee for Social Security Income (SSI or SSDI)

☐ Copy of Metro Access Card and ID Number

☐ Copy of relevant guardianship or power of attorney legal documents (if applicable)

☐ Copy of Behavior Plan, if applicable

☐ *OPTIONAL DOCUMENT: Copy of reports on relevant medical history.*

Please provide reason(s) for not submitting any of the documents that are not checked off above:

The information provided is true and complete to the best of my ability.

_____ _____

Signature of Applicant *Date*

_____ _____

Signature of Court-Appointed Legal Guardian (if applicable) *Date*

_____ _____

Signature of Person Assisting with Application (if applicable) *Date*

To be completed by The Arc Montgomery County's Admission, Discharge & Review Committee Review:

This is to certify _____ was officially admitted to or discharged from following programs of The Arc Montgomery County

- ☐ **Person Support Services**
- ☐ **Employment & Meaningful Day Services**
- ☐ **Community Living Services**

at a meeting of the Admission and Discharge Review Committee on_____ (DATE).

_____

Signature Name, Title, and Date_____