APPLICATION CHECKLIST

Thank you for your interest in DDA-funded support services provided by The Arc Montgomery County. To begin the admissions process, please submit the following information to the corresponding supervisor listed below.

- ☐ Application for DDA-Funded Support Services (following pages)
- ☐ Copy of most recent IP/PCP, whichever is applicable
- ☐ Copy of most recent Psychological Evaluation
- ☐ Pertinent Medical History
- ☐ Copy of Behavior Plan, if applicable

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!

Employment & Meaningful Day Services
Kelli Hunter-Bennett, *KelliH@arcmontmd.org*

Includes: Career Exploration, Employment Discovery and Customization, Employment Services, Supported Employment, Community Development, Day Habilitation (volunteering and leisure/recreational activities)

Inclusive Living Services
Kari Borgealt, *KariB@arcmontmd.org*

Includes Personal Supports (in-home skill building, community inclusion) and Community Living (full residential support)

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 & Meaningful Day Services Kelli Hunter-Bennett, *KelliH@arcmontmd.org*

- ☐ Career Exploration
- ☐ Employment Discovery and Customization
- ☐ Employment Services
- ☐ Supported Employment
- ☐ Community Development
- ☐ Day Habilitation (to include volunteering and leisure/recreational activities)

Inclusive Living Services Kari Borgealt, *KariB@arcmontmd.org*

- ☐ Personal Supports (in-home skill building, community inclusion)
- ☐ Community Living (full residential support)

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

Name: ____
First *Middle* *Last*

Street Address: ____

City: ______________________ State: __________ Zip: __________

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.)*

Race: ☐ 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.):

____

Applicant benefits received: ☐ Medicaid ☐ Medicare ☐ Social Security

Does Applicant have a court-appointed legal guardian? ☐ Yes ☐ No If yes, provide guardian's full name: ____

Applicant Medical Information

Primary Disability: ____________________

Cause of Disability: ____________________

When Diagnosed: ____________________ By Whom: ____________________

Primary Physician: ____________________ Phone: ____________________

Medical Assistance Number: ____________________ Medicare Number: ____________________

Private Insurance Company: ____________________

Private Insurance Identification Number: ____________________

Circle 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)	

Explanations (use additional paper if needed):

Provide the following information about all medications taken by Applicant.

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

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.

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

Describe Behaviors of Concern:

Supervision Requirements

Please circle 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 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 circle 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 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.

	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	

Additional Information

Which DDA Waiver(s) is Applicant approved for and/or accessing at this time? Circle all that apply.

Family Supports	**Community Supports**	**Community Pathways**

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

For people seeking Personal Supports, list and describe all pets in the home:

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

First Name	Last Name	Relationship	Age

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

Primary Contact

Name: ____
First *Last*

Relationship: ____

Street Address: ____

City: ____________________ State: __________ Zip: __________

Email: ____________________ Phone: ____________________

Secondary Contact

Name: ____
First *Last*

Relationship: ____

Street Address: ____

City: ____________________ State: __________ Zip: __________

Email: ____________________ Phone: ____________________

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

If yes, who assisted Applicant? ____

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*