

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, Employment@TheArcMoCo.org, MeaningfulDay@TheArcMoCo.org

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

Community Living Services

Kari Borgealt, CommunityLiving@TheArcMoCo.org

Includes: Community Living (full residential support at one of the 30+ single-family homes, townhomes, or condos operated by The Arc) and Supported Living (residential support for people who live in their own homes with their daily community living needs.)

Personal Supports

Adam McArthur, PersonalSupports@TheArcMoCo.org

Includes: 1:1 support designed to increase independence, community inclusion and goal oriented, in-home skill building. Personal Supports includes transportation to and from local community activities and events of your choosing. Support can be provided up to 7 days per week and the schedule will be agreed upon based on the person's needs.

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

- | | |
|--|--|
| <input type="checkbox"/> Career Exploration
<input type="checkbox"/> Employment Discovery and Customization
<input type="checkbox"/> Follow Along Supports | <input type="checkbox"/> Job Development
<input type="checkbox"/> Ongoing Job Supports
<input type="checkbox"/> Supported Employment |
|--|--|

Meaningful Day Services

Kelli Hunter–Bennett, MeaningfulDay@TheArcMoCo.org

- Community Development Services (to include volunteering, leisure/recreational activities, and 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

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

<input type="checkbox"/> Family Supports	<input type="checkbox"/> Community Supports	<input type="checkbox"/> Community Pathways
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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 Number: _____ Medicare Number: _____

Private Insurance Company: _____

Private Insurance Identification Number: _____

Check all that apply and provide explanations as necessary.

- | | | |
|--|---|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Dietary Needs/Restrictions | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Work Restrictions | <input type="checkbox"/> Physical Disability |
| <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Vision Impairment | <input type="checkbox"/> Speech Impairment |
| <input type="checkbox"/> Psychiatric Diagnosis | <input type="checkbox"/> Sun Sensitivity | <input type="checkbox"/> Adaptive Equipment |
| <input type="checkbox"/> Choking/Aspiration | <input type="checkbox"/> Other (please specify) | |

Explanations (use additional paper if needed):

Provide the following information about all medications taken by Applicant. Please attach paperwork if additional medication is taken as necessary.

<i>Medication Name</i>	<i>Dose/Time</i>	<i>Reason Taken</i>	<i>Administration</i>
			<input type="checkbox"/> Self <input type="checkbox"/> Others
			<input type="checkbox"/> Self <input type="checkbox"/> Others
			<input type="checkbox"/> Self <input type="checkbox"/> Others
			<input type="checkbox"/> Self <input type="checkbox"/> Others
			<input type="checkbox"/> Self <input type="checkbox"/> Others
			<input type="checkbox"/> Self <input type="checkbox"/> 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 mark which description best reflects Applicant’s needs.

<input type="checkbox"/> I need ongoing supervision and cannot be left without line of sight supervision.	<input type="checkbox"/> I need supervision when involved in a structured setting.	<input type="checkbox"/> I need occasional supervision in a structured setting.	<input type="checkbox"/> I need little supervision if expectations and boundaries are defined.	<input type="checkbox"/> I require 1:1 medical support.	<input type="checkbox"/> I require 1:1 behavioral support.	<input type="checkbox"/> I do not need supervision.
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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.

<input type="checkbox"/> I do not independently access transportation and need support while on board a vehicle.	<input type="checkbox"/> I need door-to-door transportation.	<input type="checkbox"/> I have Metro Access.	<input type="checkbox"/> I use Metro Access. # _____	<input type="checkbox"/> I use public transportation (with or without travel training).
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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).

<i>Program/Activity/Employment</i>	<i>Contact Person</i>	<i>Contact Phone</i>	<i>Dates Attended</i>	<i>Why Left?</i>

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? _____

	<i>Received?</i>	<i>If yes, please provide monthly amount</i>
SSI (Social Security Income)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
SSDI (Social Security Disability Income)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other (describe)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other (describe)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other (describe)	<input type="checkbox"/> Yes <input type="checkbox"/> No	

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