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@arcmontmd.org*, *MeaningfulDay@arcmontmd.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@arcmontmd.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@arcmontmd.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@arcmontmd.org

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

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

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

Community Living Services Kari Borgealt, CommunityLiving@arcmontmd.org

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

Personal Supports Adam McArthur PersonalSupports@arcmontmd.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.

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

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.

☐ 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. Please attach paperwork if additional medication is taken as necessary.

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 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 ______________________

	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	

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? ______________________

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*