



Andrew J. Spano
County Executive

Department of Community Mental Health
Grant E. Mitchell, M.D.
Commissioner

Dear Consumer/Parent/Advocate:

Welcome to the Westchester County Department of Community Mental Health, Developmental Disabilities Services Office. Our goal is to assist you access appropriate services. Enclosed is the Developmental Disabilities Registration and Consent to Release Information forms. Please complete as much of the registration form as you can. You may leave some questions blank if you do not have the information or are uncertain.

The Registration form in itself is not sufficient for eligibility determination. In addition, you will need to include the following documentation and/or reports which are required to determine eligibility:

- A full scale psychological evaluation, completed within the last 3 years, establishing IQ
- An adaptive behavior scale such as the Vineland II or the ABAS II
- A psychosocial report, social history or other background report that indicates that the disability occurred before the age of 22
- A physical evaluation completed within the last year, including diagnosis
- Any specialty reports relevant to the individual (neurological, psychiatric, etc.)
- Treatment summaries or reports from any previous or current psychiatric hospitalizations
- Any previous evaluations referenced in the above documentation (i.e. a previous psychological evaluation)
- Current IEP or Pre-school evaluations

Please note that while this office will assist you through the eligibility process, it is your responsibility to gather all the required information, as we do not solicit or request information for eligibility determination. Please forward these and any other evaluations that would assist us in completing an eligibility packet to my attention. This information will be submitted to the Hudson Valley Developmental Disabilities Services Office to determine eligibility to apply for services. Services cannot be applied for and or approved until eligibility has been established. If you have any questions, please contact me at 995-5257.

Sincerely,

José E. De Jesús, M.P.A.
Program Coordinator – Developmental Disabilities Services



Developmental Disabilities Registration

Date: _____

Consumer's First Name: _____ Last Name: _____
 Current Address: _____ Zip Code: _____
 Date of Birth: ____ / ____ / ____ Age: ____ Medicaid #: _____ S.S.# ____ - ____ - ____ SSI/D? _____
 Private Insurance: Y/N Company/Policy #: _____

Disability Information (Please check all that apply:)
 I.Q: _____ Level of Mental Retardation: Mild: _____ Moderate: _____ Severe: _____ Profound _____
 Epilepsy/Seizure disorder _____ Cerebral Palsy _____ Autism _____ Neurological Impairment _____
 Orthopedic Impairment: _____ Emotional Disability: _____ Other: _____
Circle
 Ambulatory: (Y/N) Ambulation Problems: _____

Correspondent's Name: _____ Relationship : _____
 Address: _____ Zip Code: _____
 Home Phone: () _____ - _____ Work Phone: () _____ - _____

School or Day Program: _____ Program Contact _____
 Program Address: _____ Phone: () _____ - _____
 Program City and State: _____

Does consumer require residential assistance? Y / No When?: _____
 Does consumer need support in the home? Y / No What service are your seeking? _____

General Comments: _____

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I hereby authorize the release of information from the records of:

To the Westchester County Department of Community Mental Health, 112 East Post Road, White Plains, New York, 10601 for the purpose of arranging needed services. I understand this authorization does give Westchester County Department of Community Mental Health the authority to release said information when there is a need to arrange services on behalf of the above named client.

I understand that I may revoke this consent at any time.

Consumer's Signature

Signature of person authorized to act on
behalf of the consumer

Consumer's Address

Relationship of authorized person

Address of authorized person

Witnessed by: _____
Signature

Address:

Date: _____

Transmittal for Determination of Developmental Disability

Verification of an individual's qualifying developmental disability is required for determination of eligibility for OMRDD services. Complete this form and submit it to your local DDSO. (See Instructions on page 2).

Documentation demonstrating a disability prior to age 22 must be attached.

Contact your local DDSO if you have questions or require assistance in filling out this form.

Please Type or Print Legibly. An * indicates required information.

***Section 1. Individual's Information**

*Name:		TABS ID (if known):		*SS#:	
*Date of Birth: / /	Medicaid #:	*County of Residence:		*Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
*Home Address:			Mailing Address (if different):		
*City:	*State:	*Zip:	City:	State:	Zip:
*Phone: ()			*Also Known As :		

*Send information to (Check as many as desired):

1. Self -Home 2. Self - Mailing Address
 3. Parent/Advocate 1 (Complete Section 2 – P/A1 Name & Address) **Note:** Do not check 3 or 4 if the Advocate is the Agency listed in Section 3.
 4. Parent/Advocate 2 (Complete Section 2 – P/A2 Name & Address)

Section 2: Involved Parents or Advocates - Use address where mail is received. Optional unless 3 or 4 is checked above.

P/A1 Name:			P/A2 Name:		
Address:			Address:		
City:	State:	Zip:	City:	State:	Zip:
Phone: ()	Country:		Phone: ()	Country:	

Section 3: Referring Agency Information (if applicable) - Automatically receives information if completed.

Agency Name:			
Agency Code (if known):		Street Address:	
Agency Contact:			
Phone: ()		City:	State: Zip:

***Section 4: Check the services you are interested in receiving if determined eligible**

1. Developmental Disability Determination only – No services requested at this time.

2. Individualized Support Services (ISS) 3. Respite Center 4. Residential Habilitation – IRA

5. Residential Habilitation – At Home 6. Intermediate Care Facility (ICF) 7. Day Habilitation

8. Day Treatment 9. Pre-Vocational services 10. Supported Work (SEMP) 11. Care at Home

12. FET – Family Education & Training 13. CSS – Consolidated Supports & Services

14. Case Management, e.g. MSC 15. Env. Modifications/Adap. Devices 16. Art. 16 Clinic

Family Support Services: 17. Respite 18. Other Family Supports

19. Other (Specify): _____

*Completed By (Name): _____ *Date: _____

Print Legibly

*Form Completed by: 1. Self 2. Parent/Advocate 3. Agency

Following to be completed by DDSO Staff Only:

Date Received by DDSO: / /		Intake Staff Name:	
Individual's TABS ID #:	Date entered in TABS: / /	By (initials):	

**Instructions for Completion of the
Transmittal for Determination of Eligibility for OMRDD Services**
Please type or clearly print all information

General Instructions:

Complete this form and submit to your local DDSO to verify an individual's developmental disability and eligibility for OMRDD services. Documentation demonstrating disability prior to the age of 22 must be attached to the transmittal. Information about the documents the DDSO will need to determine eligibility is explained in **ELIGIBILITY FOR OMRDD SERVICES Important Facts** available on the OMRDD website [omr.state.ny.us] or from your local DDSO.

Detailed Instructions:

The Transmittal can be completed by the person who wants to know if they are eligible for OMRDD services, their parent or advocate, or the agency staff person who is assisting the person.

Section 1 Individual's Information

Name: The individual's legal name: Last name, first name, and middle initial.
TABS ID: The individual's TABS identification number. If not registered, leave blank.
SS#: The individual's 9 digit Social Security Number.
Date of Birth: The individual's date of birth, in month, day, year (MM,DD,YYYY) format
Medicaid #: The individual's Medicaid number.
County of Residence: The individual's county of residence, for example, Kings, Essex.
Sex: Put an X next to the M box for or male or the F box for female.
Home Address: The current home address of the individual.
Mailing Address: Include street/avenue, apartment number, city/town, state and zip code.
The address where the person receives mail, if different from the home address. Include the PO box/street/avenue, apartment number, city/town, state, and zip code.
Phone: The individual's phone number including area code.
Also Known as: List all names (other than legal name) the person is known by.
Include nicknames, maiden name, etc.
Send Information to: Put an X next to the box indicating where the information concerning the determination should be sent. **If a parent or advocate (other than the Agency in Section 3) is to be sent information from the DDSO, check box 3 and/or 4 and complete the appropriate parts of Section 2.** Any Agency in Section 3 will automatically receive information concerning the Determination.

Section 2 Involved Parents or Advocates - This section is optional unless box 3 or 4 of Send Information To is checked. If only one Parent/Advocate is needed use P/A1 Name and Address.

Name: The parent or advocate's name: Last name, first name, and middle initial.
Address: The address where the parent or advocate receives mail.
Include street/avenue or PO box, apartment number, city/town, state and zip code.
Phone: The parent or advocate's phone number including area code.
Country: Required only if outside the US.

Section 3 Referring Agency Information (if applicable)

Agency Name: The agency's complete name.
Agency Code: The agency's OMRDD agency code, if known.
Agency Contact: Name of the agency staff person to be contacted regarding the eligibility determination.
Street Address: Indicate the address where the agency contact receives mail. Include the PO box/street, city/town, and zip code.
Phone: The agency contact's phone number including area code and any extension.

Section 4 Place an X in box 1 for a determination of developmental disability only. Or, place an X in the box next to each service the individual is interested in receiving **IF** determined eligible for OMRDD services.
NOTE: The Transmittal **is not** an application for services.

Completed by: Legibly print the name of the person who completed the form and the date on which the form is completed.
Form Completed by: Put an X in the appropriate box to indicate who completed the form (the individual/SELF, Parent or Advocate, or Agency staff).

Submit the completed form and required documentation to your local DDSO.