NYS Office For People With Developmental Disabilities *Form* # ELI (9/2012)

Transmittal Form for Determination of Developmental Disability

Proof of a person's qualifying developmental disability is required in order to determine eligibility for OPWDD services. Complete this form and send it to your local Developmental Disabilities Regional Office. (See Instructions on page 2)

ATTACH: Copies of Records that are evidence of a disability prior to age 22

Contact your local DDRO if you have questions or need help to fill out this form.

Please Type or Print a Readable Copy. An * indicates required information.

***Section 1. Person's Information**

*Name:			TABS ID (if known):	*SS#:
*Date of Birth:	Medicaid #:	* County of Residence:		*Sex: ☐ M ☐ 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)
4. ☐ Parent/Advocate 2 (Complete Section 2 P/A2 Name & Address)
5. ☐ PASRR Coordinator

Note: Do not check 3 or 4 if the Advocate is the Agency listed in Section 3.

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. Community Habilitation ☐ 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. Environmental Modifications/Adaptive Devices

☐ 16. Art. 16 Clinic Family Support Services: ☐ 17. Respite ☐ 18. Other Family Supports

☐ 19. PASRR Level II Assessment ☐ 20. Other (specify):

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

Print Legibly

***Form Completed by:** 1. ☐ Self 2. ☐ Parent/Advocate 3. ☐ Agency 4. ☐ PASRR Coordinator

Following to be completed by DDRO Staff Only:

Date Received by DDRO:	**Intake Staff Name:**	
Person's TABS ID #:	**Date entered in TABS:**	**By (initials):**

Clear Form

Instructions for Completing
Transmittal form
Please type or clearly print all information

General Instructions:
Complete this form and send it to your local DDRO with copies of records. Copies of records that prove disability prior to the age of 22 must be attached to the transmittal. These will be used for the OPWDD eligibility review. If you have questions about the kinds of records needed for the eligibility review, see ***ELIGIBILITY FOR OPWDD SERVICES*** **Important Facts.** The Facts sheet can be found on the OPWDD website [http://www.opwdd.ny.gov] or requested from your local DDRO.

Detailed Instructions:
This Transmittal form can be completed by: the person who wants to know if they are eligible for OPWDD services, their parent or advocate, or an agency staff person who is helping the person.

Section 1 **Person's Information**

Name:	The person's legal name: Last name, first name, and middle initial.
TABS ID:	The person's TABS identification number. If not registered, leave blank.
SS#:	The person's 9 digit Social Security Number.
Date of Birth:	The person's date of birth, in month, day, year (MM/DD/YYYY) format. (e.g. 04/03/1998)
Medicaid #:	The person's Medicaid number.
County of Residence:	The individual's county of residence, (for example, Kings, Essex.)
Sex:	Put an **X** in the **M** box for a boy/man or in the **F** box for girl/woman.
Home Address:	The person's current home address. Include street/avenue, apartment number, city/town, state and zip code.
Mailing Address:	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 person'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 about the eligibility decision should be sent. **If a parent or advocate (other than the Agency in Section 3) is to be sent information from the DDRO, check box 3 and/or 4 and fill in the Parent/Advocate parts of Section 2.** Any agency in Section 3 will automatically receive information concerning the eligibility 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.
Home Address:	The current home address of the parent or advocate. Include street/avenue, apartment number, city/town, state and zip code.
Mailing Address:	The address where the parent or advocate *receives mail*, **if different** from the home address. Include the PO box or street/avenue address, apt. #, city/town, state, and zip code.
Phone:	The parent or advocate's phone number, including area code.

Section 3 **Referring Agency Information (if applicable)**

Agency Name:	The agency's complete name.
Agency Code:	The agency's OPWDD agency code, if known.
Agency Contact:	Name of the agency staff person to be contacted about the eligibility determination.
Street Address:	Fill in the address where the agency contact receives mail. Include the PO box or street, address, 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 person is interested in receiving **IF** he/she is determined to be eligible for OPWDD 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 when the form is completed.
Form Completed by:	Put an X in the correct box to indicate who completed the form (the person/SELF, Parent or Advocate, Agency staff, or PASRR Coordinator).

Submit the completed form and required records to your local DDRO.