NYS Office For People With Developmental Disabilities Form # ELI-01(9/20/2011)

Transmittal for Determination of Developmental Disability

Verification of an individual's qualifying developmental disability is required for determination of eligibility for OPWDD 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: ☐ M ☐ F
*Home Address:		Mailing Address (if different):	
*City:	*State: NY *Zip:	City:	State: NY 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: NY	Zip:	City:	State: NY	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: NY	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. Env. Modifications/Adap. 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 DDSO Staff Only:

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

Clear Form

Instructions for Completion of the
Transmittal for Determination of Eligibility for OPWDD 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 OPWDD 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 OPWDD SERVICES Important Facts*** *available on the* OPWDD website [OPWDD.ny.gov] or from your local DDSO.

Detailed Instructions:
The Transmittal can be completed by the person who wants to know if they are eligible for OPWDD 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. 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 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.
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/street/avenue, 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 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 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 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, Agency staff, or PASRR Coordinator).

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