

# Developmental Disabilities

## Services

Georgia Department of Human Resources  
**OFFICE OF DEVELOPMENTAL DISABILITIES**

### APPLICATION FOR DEVELOPMENTAL DISABILITIES/ MENTAL RETARDATION SERVICES

IF YOU NEED ASSISTANCE COMPLETING THIS APPLICATION, PLEASE CONTACT THE LOCAL INTAKE AND EVALUATION OFFICE BY CONTACTING: 1-800-348-3503 (INTAKE AND EVALUATION OFFICE)

#### I. GENERAL INFORMATION (APPLICANT)

Name: \_\_\_\_\_  
First Middle Last

Address: \_\_\_\_\_  
Street Address (Apartment Number if Applicable)

\_\_\_\_\_ City County State Zip Code

Mailing Address (if different) \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Area Code Marital Status: S M D W Sex: \_\_\_\_\_

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Medicare # \_\_\_\_\_

Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Medicaid # \_\_\_\_\_

**PRIMARY CONTACT:** \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ City County State Zip Code

Relationship to Applicant: \_\_\_\_\_ Telephone Number: \_\_\_\_\_  
Area Code

**LEGAL STATUS OF APPLICANT:** \_\_\_Minor \_\_\_Competent \_\_\_Legally Incompetent (Documentation Required)

Name of Legal guardian, if applicable: \_\_\_\_\_

Address: \_\_\_\_\_  
Street Address (Apartment Number if Applicable)

\_\_\_\_\_ City County State Zip Code

Relationship to Applicant: \_\_\_\_\_ Telephone Number: \_\_\_\_\_  
Area Code

**II. ASSESSMENT OF DEVELOPMENTAL DISABILITY AND ELIGIBILITY**

To be eligible for Georgia’s Developmental Disabilities Waiver services, you must be:

- a. Medicaid eligible
- b. Have mental retardation since birth or before age 18, or another developmental disability since birth or before age 22, which requires similar services to those needed by people with mental retardation.
- c. Be at risk for going into an institution for people with mental retardation if you do not get the services you need in your community.

During your initial screening appointment, specific medical information will be collected to confirm the disability. Please read the *Information for Applicant* checklist at the front of this application, and have items or copies available.

**III. SERVICE NEEDS**

Describe the type of services you believe you need. For example do you need help with getting a job, do you need assistance to get dressed, do you need family support or do you need some place to live.

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**IV. COMPLETED BY:**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Check one:    \_\_\_Applicant            \_\_\_Guardian            \_\_\_Other: \_\_\_\_\_

Printed Name: \_\_\_\_\_

What is the best way to contact you?  
\_\_\_\_\_

When this application is received, it will be stamped with a date. Within fourteen working days of that date, you will be notified that your application has been received and you will be offered a screening appointment. If this does not occur, please call the Intake and Evaluation listed above.

**Return this application to:**

**Region Five MH/DD/AD Office  
Intake & Evaluation  
1915 Eisenhower Drive, Building Two  
Savannah, GA 31406**

Please keep a copy for your records.