# Application for Consultation Services

**Consultation Services** offers an array of services to individuals with developmental disabilities and their families to help them identify and obtain benefits and resources and engage in transition and life planning that meets their specific and unique goals, needs, and interests. Services center around the individual and incorporate the needs and interests of the family in relation to the individual.

## Individual's Information

Name: ______________________________ Birthdate: __________ Gender: ☐ M ☐ F

Address: ____________________________________________

City: ____________________ County: ____________ State: ______ Zip: __________

Phone: ____________________ Email: ______________________________

Race and Ethnicity: (for demographic data purposes)

☐ American Indian or Alaska Native ☐ Asian or Pacific Islander

☐ African American ☐ Caucasian/Anglo ☐ Multi-Racial/Ethnic Group

☐ Not Hispanic ☐ Hispanic or Latino ☐ Other ____________________

Annual Household Income:

☐ <$35,000 ☐ $36,000 - $70,000 ☐ >$71,000 Is individual living in family home? ☐ Yes ☐ No

Medicaid # (if applicable):______________________ Social Security #: ______________

Place of birth: ____________________ Name of School? (if attending): `________________

How did you hear about us? ____________________________________

## Responsible Party Information

Name: ____________________________________________

Relationship to Individual (Parent/Guardian/Caregiver/Other): ______________________

Address: ____________________________________________

City: ____________________ County: ____________ State: ______ Zip: __________

Phone: ____________________ Email: ______________________________

## Diagnosis Information

Primary Diagnosis: ____________________________________

Secondary Diagnosis: ____________________________________

## Current Services

Please indicate the services you are currently receiving (check all that apply):

- ☐ ISP
- ☐ Speech Therapy
- ☐ Medicaid
- ☐ SSI
- ☐ Deeming Waiver
- ☐ IEP
- ☐ Occupational Therapy
- ☐ Medicare
- ☐ SSDI
- ☐ Waiver Program ______________________________
- ☐ BIP
- ☐ Physical Therapy
- ☐ GA Vocational Rehabilitation Agency (GVRA)
- ☐ Behavioral Therapy /Support

## Services Needed

Please indicate the type of services you are interested in receiving (select one):

☐ Benefits Navigation ☐ Resource Coordination ☐ Resource Coordination & Direct Advocacy

Please indicate the program services you are interested in receiving (check all that apply):

- ☐ Education-Based Services
  - ☐ IEP Review/Support ☐ ISP Review/Support
  - ☐ Deeming Waiver
  - ☐ Family Support
  - ☐ Financial Assistance ☐ Outreach Support (Direct Services)
- ☐ Transition Services
  - ☐ Social Security
  - ☐ Waiver Program
    - ☐ NOW/COMP ☐ Other: ______________________
    - ☐ Family Support
    - ☐ Financial Assistance ☐ Outreach Support (Direct Services)
- ☐ Futures Planning Services
  - ☐ My 360 View ☐ My Profile ☐ MAPS ☐ PATH ☐ Letter of Intent
- ☐ Workshops

## Signatures

Individual: ______________________________ Date: ____________
*Signature*

Responsible Party: ______________________________
*Signature*

AADD Consultant: ______________________________ Date: ____________
*Signature*

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