ARLINGTON DEPARTMENT OF HUMAN SERVICES
AGING AND DISABILITY SERVICES DIVISION
Clinical and Developmental Services Bureau
Developmental Services

Arlington Community Services Board
2100 Washington Blvd, 4th floor
Arlington, Virginia 22204
(703) 228-1700

APPLICATION FOR DEVELOPMENTAL SERVICES

Date of Application:			
I. Personal Information			
First Name:	Middle Name:	Last Name:	
Preferred Name:			
Street Address:			
City:	State:	Zip Code:	
Home Phone:	Cell Phone:	E-Mail:	
Preferred Contact Method: ☐ Phone ☐ E-Mail ☐ Mail ☐ Other:			
Date of Birth:	Age:	Place of Birth:	
Gender Pronoun (He, She, Him, Her, His, They, Them):	Marital Status:	Height:	Weight:
Preferred Language:	Race:	Ethnicity:	
Communicates By (check all that apply): ☐ Speech ☐ Sign Language ☐ Gestures ☐ Communication Device ☐ Other (please specify):			
Present Living Situation:			
II. Referral Source			
Referred By:		Relationship:	
Phone Number:		E-mail:	
Preferred Language:		Preferred Method of Communication:	
Should referral source be copied on future communication regarding the application? ☐ Yes ☐ No			

III. FAMILY INFORMATION		
Name:		
Address:		
Home Phone:	Cell Phone:	E-Mail:
Relationship:		Date of Birth:
Preferred Language:		
Name:		
Address:		
Home Phone:	Cell Phone:	E-Mail:
Relationship:		Date of Birth:
Preferred Language:		

Has the applicant ever had a capacity hearing in court? ☐ Yes ☐ No	
If yes, please fill out information below:	
Court Date:	Result:
Court:	Place/Location:
Does the applicant have a court appointed legal guardian? ☐ Yes ☐ No	
Name of Guardian(s):	Is guardianship limited to a specific area? ☐ Yes ☐ No

Home Phone:	Cell Phone:	E-mail:

IV. DEVELOPMENTAL, MEDICAL AND PSYCHOLOGICAL INFORMATION	
Name of Primary Care Physician:	
Address:	
Phone:	Date of Last Visit:
Does the applicant have a seizure disorder? ☐ Yes ☐ No	
If yes, list type:	If yes, describe frequency:
Developmental Disability/Disabilities:	
Date of last Psychological Examination, if applicable:	Agency/Examiner:
PHYSICAL DISABILITIES/MEDICAL ISSUES, If Any:	
Is the applicant ambulatory?	☐ Yes ☐ No
Does the applicant have orthopedic issues?	☐ Yes ☐ No
Does the applicant have cerebral palsy?	☐ Yes ☐ No
Does the applicant have epilepsy?	☐ Yes ☐ No
Does the applicant have cardiac issues/cardiac disease?	☐ Yes ☐ No

Does the applicant have diabetes?	☐ Yes ☐ No
Does the applicant have visual impairment? If Yes, does the applicant wear glasses? If Yes, is the applicant legally blind?	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
Does the applicant have hearing impairment? If Yes, does the applicant wear hearing aids? If Yes, is the applicant deaf?	☐ Yes ☐ No If yes, ☐ Left Ear ☐ Right Ear ☐ Yes ☐ No ☐ Left Ear ☐ Right Ear ☐ Both

Does the applicant have other disabilities not listed above? ☐ Yes ☐ No

Please list:

List any physical restrictions or limitations:

Is the applicant currently taking any medications? ☐ Yes ☐ No If yes, please list below (use back of sheet if needed):

Medication	Dosage	Frequency

Has the applicant ever received mental health therapy? ☐ Yes ☐ No

If yes, please list dates of therapy/providers below:

Does the applicant have any behavioral issues or concerns? ☐ Yes ☐ No

If yes, please describe:

Please note any special concerns:

HOSPITALIZATIONS:		
Hospital:		Dates of Hospitalization:
Address:		
Reason for Hospitalization:		
Hospital:		Dates of Hospitalization:
Address:		
Reason for Hospitalization:		
Hospital:		Dates of Hospitalization:
Address:		
Reason for Hospitalization:		
OTHER CLINICS/SPECIALISTS PROVIDING SERVICES TO APPLICANT:		
Name:	Service/Specialty:	Phone:
V. EDUCATIONAL BACKGROUND		
Name of School	City, State	Dates Attended
		From: To:
		From: To:
		From: To:
		From: To:
VI. VOCATIONAL BACKGROUND		
Is the applicant currently active with Department of Aging and Rehabilitative Services (DARS)? ☐ Yes ☐ No		
If yes, DARS Address:		
DARS Counselor's Name:		DARS Counselor's Phone:

Is the applicant currently enrolled in training or a day program? ☐ Yes ☐ No If yes, please give name(s) and date(s):		
Name:	From: To:	
Name:	From: To:	
Has the applicant completed a vocational evaluation? ☐ Yes ☐ No If yes, please give name(s) and date(s):		
Name:	From: To:	
Name:	From: To:	
EMPLOYMENT HISTORY:		
Is the applicant currently employed or previously employed? ☐ Yes ☐ No If yes, please provide the following information:		
Employer:	From: To:	☐ Part Time ☐ Full Time
Address:		
Position:		Phone:
Reason for Leaving:		
Employer:	From: To:	☐ Part Time ☐ Full Time
Address:		
Position:		Phone:
Reason for Leaving:		
Employer:	From: To:	☐ Part Time ☐ Full Time
Address:		
Position:		Phone:
Reason for Leaving:		

VII: OTHER PROGRAM INFORMATION:

PLEASE LIST ALL AGENCIES, PRIVATE OR PUBLIC, FOR WHICH THE APPLICANT CURRENTLY HAS CONTACT:		
Name:	From: To:	Contact Person:
Address:		
Name:	From: To:	Contact Person:
Address:		
Name:	From: To:	Contact Person:
Address:		
Name:	From: To:	Contact Person:

Address:				
VIII: SKILL DEVELOPMENT AND FUNCTIONAL LEVEL				
PLEASE INDICATE WHAT LEVEL OF ASSISTANCE, IF ANY, THE APPLICANT RECEIVES IN THE FOLLOWING AREAS:				
EATING	☐ Independent	☐ Verbal Prompt	☐ Physical Assistance	☐ Unable to Perform
TOILETING	☐ Independent	☐ Verbal Prompt	☐ Physical Assistance	☐ Unable to Perform
BATHING	☐ Independent	☐ Verbal Prompt	☐ Physical Assistance	☐ Unable to Perform
WASHING HAIR	☐ Independent	☐ Verbal Prompt	☐ Physical Assistance	☐ Unable to Perform
BRUSHING HAIR	☐ Independent	☐ Verbal Prompt	☐ Physical Assistance	☐ Unable to Perform
SHAVING	☐ Independent	☐ Verbal Prompt	☐ Physical Assistance	☐ Unable to Perform
MENSTRUAL CARE	☐ Independent	☐ Verbal Prompt	☐ Physical Assistance	☐ Unable to Perform
DRESSING	☐ Independent	☐ Verbal Prompt	☐ Physical Assistance	☐ Unable to Perform
USING THE TELEPHONE	☐ Independent	☐ Verbal Prompt	☐ Physical Assistance	☐ Unable to Perform
MONEY MANAGEMENT	☐ Independent	☐ Verbal Prompt	☐ Physical Assistance	☐ Unable to Perform
USING BUS/METRO	☐ Independent	☐ Verbal Prompt	☐ Physical Assistance	☐ Unable to Perform
SHOPPING	☐ Independent	☐ Verbal Prompt	☐ Physical Assistance	☐ Unable to Perform
TELLING TIME	☐ Independent	☐ Verbal Prompt	☐ Physical Assistance	☐ Unable to Perform
PLEASE DESCRIBE THE FOLLOWING SKILLS/ABILITIES::				
Reading:				
Writing:				
Expressive Communication:				
Receptive Communication:				
Routine/Activities:				
IX. FINANCIAL INFORMATION				

Income Source:	Associated ID Number:	Amount per Month
Social Security (SSA or SSDI)		
Supplemental Social Security Income (SSI)		
Personal Income (Wages, Tips, etc.)		
Other Sources (Trusts, Retirement, Annuities, Etc.) Please specify:		

Health Insurance:	Policy Number
Does the applicant have Medicaid? ☐ Yes ☐ No	
Does the applicant have Medicare? ☐ Yes ☐ No	
Does the applicant have other health insurance? Specify:	

X. SERVICES REQUESTED

Please list the services you are requesting from Arlington CSB:

☐ Case Management

☐ Developmental Disability Waiver Waitlist

☐ Residential Services (e.g. In-Home Residential Supports, Respite, Group Home)

☐ Day Support Services

☐ Employment Services (e.g. Job Coaching, Job Development

☐ Behavioral Health

☐ Behavioral Support Services

☐ Family Supports

☐ Housing Assistance

☐ Other (please specify):

XI. Application completed by:

Printed Name:	Relationship to Applicant :
Signature:	Date:

Signature of the individual applying for services, or the legally authorized representative, is required if either is different from the above person:

Applicant or Legally authorized Representative: Printed Name:

_____ _____

Signature: Date:

THE FOLLOWING IS TO BE COMPLETED BY DDS STAFF:
XII. CLIENT SERVICES COORDINATION
Date application was received:
Name of DS Staff Processing Application:
Assigned Welligent ID#: