

ARKANSAS DEPARTMENT OF HUMAN SERVICES  
DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES  
DDS DIRECTOR'S OFFICE POLICY MANUAL

Policy Type	Subject of Policy	Policy No.
Administrative	Application & Services Referral	1020

1. Purpose. This policy establishes the request for services, application, eligibility determination and referral procedures for obtaining services from Developmental Disabilities Services.
2. Scope. This policy applies to all DDS employees, persons with developmental disabilities and their families, and any other interested parties.
3. Procedural Guidelines. All requests for services shall be forwarded/received by the appropriate DDS Service Coordinator.
  - A. Upon receipt of a request for services, the following forms will be provided to the applicant and/or the legally responsible party.
    1. Application for Services
    2. Information sheet about services options available through DDS
    3. Individual Services Implementation Plan Questionnaire (ISIP) (optional)
    4. Consent(s) for Release of Information
    5. Authorization for Services
    6. Freedom of Choice Form
    7. Financial Screening Form
  - B. When the above information (3.A.1-7) is obtained, the Service Coordinator will request all relevant records, evaluations, and legal documents.
  - C. After receiving and reviewing the above information (3.B.), the Service Coordinator will determine eligibility for DDS services.

Replacement Notation: This policy replaces DDS Policy #1020, effective December 1, 1993; November 2, 1981; December 30, 1982; May 25, 1983; May 31, 1985; January 8, 1987; and September 1, 1987.

Effective Date: December 1, 1997  
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Sheet 1 of

References: DDS Director's Office Policy #1035; #3019 and Field Services Operations Manual Referral Procedures; Act 729 of 1993; Act 513 of 1981 Arkansas Statute 20-48-101.

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- D. If eligibility for DDS services cannot be determined, the Service Coordinator will immediately refer application/information to the Service Coordinator Manager for a final determination.
- E. Upon determination of eligibility, the Service Coordinator will notify the applicant and/or the legally responsible party that:
1. The applicant is eligible for services from DDS, and a face to face meeting is scheduled to complete the process, or;
  2. The applicant is ineligible and referrals to and suggestions about other agencies are provided, as well as the opportunity to appeal the decision.
- F. For an eligible applicant, a face to face meeting will be held. During that contact, the following will be accomplished.
1. Review of the description of service options and written documentation of the choice selected and/or referral(s) to be made;
  2. Review and/or expansion of ISIP Questionnaire (optional);
  3. Ensure completion of the financial screen;
  4. Complete age appropriate screen as needed;
  5. Collect additional related information;
  6. Complete documents as needed for service referrals.
- G. Based on information provided, the Service Coordinator will input client information into the DDS Data Base System.
- H. Within 15 working days from the date of the face to face meeting, the Service Coordinator will develop a narrative Social History, which shall include all factors related to the needs/requests of the applicant.
- I. The Service Coordinator will open a Master File.
- J. The Service Coordinator will make referrals as indicated by the Social History and maintain written documentation of responses in case notes placed on the DDS Data Base System for placement in the Master File.
- K. The Service Coordinator will maintain documentation of actions taken, verify referrals, conduct follow-up activities, and assure documents are retained in a Master File.

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ARKANSAS DEPARTMENT OF HUMAN SERVICES  
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4. If an applicant is determined to be ineligible for services, that individual or the parent/guardian is to be informed of the right to appeal the decision as outlined in DDS Policy #1076.

Effective Date: December 1, 1997

Sheet 3 of 3  
Policy 1020  
Attachment

DEPARTMENT OF HUMAN SERVICES  
DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES

**APPLICATION FOR SERVICES**

Date of Application:

\_\_\_\_\_

Applicant's Name:

\_\_\_\_\_

Applicant's Address:

\_\_\_\_\_

Applicant's Date of Birth:

\_\_\_\_\_

Applicant's County of Residence:

\_\_\_\_\_

Telephone:

\_\_\_\_\_

Legal Status:

\_\_\_\_\_

S.S.I. Recipient:

Yes: \_\_\_\_\_ No: \_\_\_\_\_

Social Security Number  
of applicant:

\_\_\_\_\_

Medicaid # of Applicant:

\_\_\_\_\_

Medicare # of Applicant:

\_\_\_\_\_

Insurance Company Name and

Number:

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Name of Parent/Guardian:

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Address:

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County of Residence:

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Telephone:

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Relationship:

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Work Address:

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Work Telephone Number:

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Directions:

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Primary Disability:

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Secondary Disability:

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Applicant's Physician:

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Address:

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Telephone:

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Services Requested:

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Emergency Contact:

Name:

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Address:

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Telephone:

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Referred by: \_\_\_\_\_  
(Name) (Title) (Telephone Number)

\_\_\_\_\_  
Signature of Person  
Date

\_\_\_\_\_  
Signature of parent or guardian  
Relationship  
Date

\_\_\_\_\_  
Witness  
Date

(If person is not incapacitated,  
but unable to sign due to physical  
disability)

Unless the person is legally incapacitated, he/she must sign this form. If he/she is legally incapacitated, it must be signed by the personal guardian (accompanied by proof of guardianship). If person is a minor, parent may sign. If person is not incapacitated but unable to sign because of physical disability his/her mark or consent must be witnessed.

