agency for persons with disabilities

State of Florida

Rick Scott
Governor

Barbara Palmer
Director

Northeast Region

3631 Hodges Boulevard
Jacksonville, Florida
32224

(904) 992-2440
Fax:
(904) 992-2442

Toll Free:
(866) APD-CARES
(866-273-2273)

Please complete and sign the application and return to the address below within thirty (30) calendar days of the date of this letter. Please contact us if something comes up that you cannot complete this application within 30 days. We will be glad to grant an extension of time (an additional 30 days) to complete the application.

A completed application also includes the following to meet residency and identification requirements:

- Proof of Residency – Florida ID or copy of a bill (electric, water, cable or phone – any of these will meet the requirement).
- Proof of Identity – Copy of birth certificate, Florida State ID or school photo identification card (any one of these will meet the requirement).
- Proof of Guardianship (if applicable).
- Copy of applicant's social security card.
- Copy of any medical records to confirm a diagnosis of Cerebral Palsy, Spina Bifida, Prader-Willi Syndrome or Down Syndrome.
- Copy of a psychological evaluation showing a functional IQ and adaptive behavior score to confirm a diagnosis of an Intellectual Disability.
- Copy of an Autism diagnosis completed by a Florida licensed psychiatrist or psychologist, a board certified pediatric neurologist, a board certified developmental pediatrician, or the same information from another state if the evaluator is licensed through the same credentials as shown in this current descriptive statement.

Please return the application and all documents to:
1219 Dunn Avenue
Daytona Beach, FL 32114
Or you may fax it to 386-366-9294.

If you have any questions regarding the application forms or supporting documents, please do not hesitate to contact us at (386) 257-1700 or (844)865-1172.

Sincerely,

Agency for Persons with Disabilities

agency for persons with disabilities

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Rick Scott
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32224

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Uniform Legal Residency Requirements:

In accordance with C. 393.065 (1) F.S., only individuals whose domicile is in Florida are eligible for services. In order to be domiciled in Florida, the individual must be a United States citizen or resident alien.

Per Ch. 222.17 (1) F.S., an individual who resides in Florida for any length of time can demonstrate that their domicile is in Florida with one of the following:

i. Formal declaration (a sworn statement, or Notice of Intent to Domicile, filed with the clerk of the circuit court for the county in which the said person shall reside), or
ii. Florida voter registration card, or
iii. Florida driver's license or Florida state ID card, or
iv. Homestead exemption filing, or
v. Current federal income tax returns with a Florida address, or
vi. Filing of Florida intangible tax returns.

Additional evidence may include enrollment in school, a bill with an address on it, the issuance of a license tag on any motor vehicle owned by the individual or legal guardian, or other items showing a local address, so long as the intent to domicile is evidenced by one of the actions above.

Proof of Identity Requirements:

Proof of identity is required as part of the application process. These include, but are not limited to:

i. Birth Certificate;
ii. Resident Alien Card (green card);
iii. Passport;
iv. School photo identification card;
v. State for federal government photo identification card;
vi. Any other identification that would reasonably be presumed to be proof of identity.

Copy of a social security card.

At least one of the documents noted above must be provided for both the residency and identity requirement.

USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

APD's Responsibilities

The Agency for Persons with Disabilities is required by law to maintain the privacy of your protected health information in our custody. We must provide you with notice of our legal duties and privacy practices with respect to your health information. We must also follow the terms of this notice.

How APD Uses and Safeguards your Health Information

If you are a Developmental Disabilities Individual Budgeting Medicaid Waiver recipient, we use your health information to pay for your health care products and services and to operate the Developmental Disabilities Individual Budgeting Medicaid Waiver program. We may also use your health information to tell you about treatment alternatives or other health-related benefits and services.

The following are some examples of how we may use your health information:

- Coordinating supported living services.
- Placement in an intermediate care facility.
- We may share your information with a company that contracts with the State of Florida to check on the quality of care that you received.

APD may also use and disclose your health information as permitted by law, such as:

- For purposes of treatment, payment, or our operations and as otherwise required by law.
- To entities outside the Agency for purposes directly connected with the administration of the State Medicaid plan.
- In responding to public emergencies, access to your health information may be granted to persons or Agency representatives who are subject to standards of confidentiality comparable to those of APD. Such other agencies may include the Federal Emergency Management Agency (FEMA) or the Centers for Disease Control (CDC).
- Where disclosure would assist in determining eligibility for benefits, amount of medical assistance payment or otherwise assists the Agency in the administration of the Medicaid program.
- To the confidential Florida abuse hotline in order to report abuse, neglect and/or domestic violence as per criteria and conditions imposed on the Agency by law.
- For health oversight activities and/or administration of the Medicaid program, such as inspections, investigations, and audits.
- To conduct research to benefit the Medicaid program.
- Other uses or disclosures of your protected health information require your or your personal representative's written authorization. For example, we will not use or disclose psychotherapy notes without your written authorization or as allowed by law. We will not use or disclose your protected health information for marketing purposes without your written authorization and we will not sell your protected health information without your written authorization. We also are prohibited by law from using or disclosing genetic information for insurance underwriting purposes. At any time, you may revoke authorizations in writing. If you cannot give your authorization due to an emergency, we may release your health information if it is in your best interest.

Your Health Information Rights

You have the following rights with respect to your protected health information:

- To see or obtain a copy of your health information that is maintained by APD. We may not be able to provide health information that includes psychotherapy notes, is part of a legal case, or is otherwise excluded from disclosure by law. We may charge a copying fee.
- To request that we amend health information we maintain that you believe is incorrect or incomplete.
- To request a list of disclosures we have made of your health information. The list may not include disclosures authorized by you, disclosures for treatment, payment and health care operations, or other disclosures permitted by law.
- To request that we contact you at a different address or phone number, if contacting you about your health information at your present location would endanger you.
- To request that we limit the use and disclosure of your health information. We are not required to agree to your request.
- To request a paper copy of this notice.
- To opt-out of fundraising communications from us should the Agency ever engage in fundraising.
- To receive a notification from us following a breach of your unsecured protected health information.

Contact Information

If you have any questions, wish to make a request regarding your health information, or would like another paper copy of this notice, please contact the APD regional office in your area at the telephone number listed below. We may ask you to make the request in writing.

Central Region (Orlando): (407) 245-0440
Northeast Region (Jacksonville): (904) 992-2440
Northwest Region (Tallahassee): (850) 487-1992

Southeast Region (West Palm Beach): (561) 837-5564
Southern Region (Miami): (305) 349-1478
Suncoast Region (Tampa): (813) 233-4300

Filing a HIPAA Complaint

If you believe your privacy rights have been violated by APD or one of its employees, you may file a complaint with APD and/or the Secretary of the Department of Health and Human Services at the addresses below. You will not be retaliated against for filing a complaint.

HIPAA Privacy Officer
Agency for Persons with Disabilities
4030 Esplanade Way
Tallahassee, Florida 32399-0950
(850) 922-9309

Secretary
Department of Health and Human Services
200 Independence Ave. SW
Washington, D.C. 20201
(800) 368-1019

Future Changes to the Notice of Privacy Practices

APD reserves the right to change the terms of this notice and to make new notice provisions effective for all protected health information that we maintain. If we make a material revision to this notice, we will send a revised copy of the notice to recipient households within sixty (60) days of the revision.

Who receives the Notice of Privacy Practices

agency for persons with disabilities
State of Florida

Application for Services

Region/Field Office: _______ Phone #: ________________________

Name of APD Staff Person: ______________________ Date of Application: ___/___/_____

1. Applicant Information

Name: ____ **SS#: *** ______________________________

(Last) (First) (MI) (Suffix)

Address: ____ **Medicaid #:** ______________________________

____ **Phone #:** ______________________________

Email: ____ **Alternate Phone #:** ______________________

DOB: _______ **Sex:** ____ **Race** (for data purposes only): ☐ White; ☐ Black; ☐ Asian; ☐ Native American or Alaskan Native; ☐ Other

Ethnicity (for data purposes only): ☐ USA; ☐ Cambodia; ☐ Cuba; ☐ Ethnic Chinese; ☐ Haiti; ☐ Laos; ☐ Mexico; ☐ Nicaragua; ☐ Poland; ☐ Puerto Rico; ☐ Russia; ☐ Vietnam; ☐ Other Hispanic Country; ☐ Other Asian Country; ☐ Other Foreign Country

Primary DD Diagnosis (must select at least one): ☐ Autism; ☐ Cerebral Palsy; ☐ Intellectual Disability; ☐ Prader-Willi Syndrome; ☐ Spina Bifida; ☐ Down Syndrome; ☐ Phelan McDermid Syndrome; OR, ☐ Between the ages of 3 and 5 and at High Risk of Developing a Developmental Disability (if selecting this box, please explain):____

☐ **Secondary DD Diagnosis:** ____________________________ ☐ **Mental Health Diagnosis:** ________________________

Do you have a job paying minimum wage or better? ☐ Yes ☐ No If No, are you interested in gainful employment? ☐ Yes ☐ No

1.a. Applicant's Primary Caregiver Information

Name: ____ **DOB:** ______________________________

(Last) (First) (MI) (Suffix)

Phone #: ____ **Alternate Phone #:** ______________________

Relationship of Primary Caregiver to Applicant: ____

Does the primary caregiver have health issues that prevent them from continuing to provide care? ☐ Yes ☐ No If Yes, please indicate the medical issues: ____

Is the primary caregiver also providing primary care to a minor, elderly person or another person with a disability? ☐ Yes ☐ No If Yes, please explain: ____

Are the current caregiver responsibilities preventing them from being employed? ☐ Yes ☐ No

If the applicant is an adult (over the age of 18) has the applicant been removed from their family home by Adult Protective Services in the last 12 months? (Regardless of the result of the investigation) ☐ Yes ☐ No

2. Active Duty Military Service Member (if No to the first question, move to the next section)

Is the applicant's parent or legal guardian an active duty military service member? ☐ Yes ☐ No

If Yes, please identify by name: ____

Was the family transferred to FL as part of military assignment? ☐ Yes ☐ No

If Yes to the above, did the applicant receive home and community-based waiver services in another state? ☐ Yes ☐ No

If Yes to the above, please list services received: ____

Did the applicant move to FL to be closer to family while a parent or legal guardian is deployed? ☐ Yes ☐ No

If Yes, please explain: ____

Attached is a copy of the military service member's Uniformed Services ID Card ☐ Yes ☐ No

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3. Person Assisting Applicant

Name: ______________________ Relationship to Applicant: ______________________

(Last) (First) (MI)

Address: ______________________

Phone #: ______________________ Alternate Phone #: ______________________

Email: ______________________ Preferred Language of Applicant/Legal Guardian: ______________________

4. Services Requested

I am requesting services via the Home and Community-Based Services (HCBS) Waiver. ☐ Yes ☐ No

OR

I am requesting services in an Intermediate Care Facility. ☐ Yes ☐ No

I am requesting the following services from the Agency for Persons with Disabilities:

______________________ ______________________ ______________________

______________________ ______________________ ______________________

5. Applicant's Identity Verification (must check one) (to be filled out by APD Staff):

☐ FL Driver's License/ID Card ☐ US Passport ☐ Military/Government Issued Photo ID Card

☐ Certificate of Naturalization/Citizenship ☐ School Photo ID (only accepted for persons under the age of 16)

6. Applicant's Legal Status (select all that apply) (to be filled out by APD Staff):

☐ Between the ages of 3 and 18 and under legal custody of his/her parent(s)

☐ Between the ages of 3 and 18 with a court appointed representative

☐ Between the ages of 3 and 18 and the parents have delegated decision making under the Family Care Act using a written power of attorney or durable power of attorney

☐ 18 or older and his/her own representative

☐ 18 or older and has delegated in writing decision-making authority related to governmental benefits or medical decisions to someone else by using a power of attorney or durable power of attorney

☐ 18 or older and a court has issued letters of guardianship or guardian advocacy, naming someone other than the applicant as the decision maker for governmental benefits or medical decisions

Name of legal guardian or guardian advocate, court appointed representative or person delegated decision making authority (if applicable):

____

List type of document(s) provided as proof of legal status (if applicable): ______________________

7. Community Based Care (CBC) (if No to first question, move to next section) (to be filled out by APD Staff):

Is this applicant an active Community Based Care (CBC)/Child Welfare services recipient? ☐ YES ☐ NO

If yes, is he or she receiving out-of- home (foster care) services? ☐ YES ☐ NO

Is he or she receiving in-home (protective supervision) services? ☐ YES ☐ NO

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8. Citizenship Verification (must check one) (to be filled out by APD Staff): :

To receive services from APD, the applicant and parent or legal guardian (if applicable) must be domiciled in Florida, and the applicant must be a U.S. citizen or resident alien

Is the applicant a U.S. Citizen? ☐YES ☐NO

Place of Birth: ☐United States (What State?) __________________ ☐Other (Name of Country)__________________

If not a US citizen, must provide USCIS alien status and number (also please fill out page 6 of this application):

☐Permanent Resident ☐Other:____________________ USCIS #:________________________

Type of documentation provided for proof of citizen or alien status:

☐US Birth Certificate ☐US Passport ☐Certificate of Naturalization/Citizenship ☐Green Card ☐ USCIS Issued Form

9. Residency:

Is the person requesting services a resident of the state of Florida? ☐YES ☐NO

If the applicant is a minor, is the parent or legal guardian domiciled in Florida? ☐YES ☐NO

Has the applicant recently relocated to Florida? ☐YES ☐NO

If YES, please explain ____

Residency Verification (must check one) (to be filled out by APD Staff):

☐FL Driver's License/ID Card; ☐Voter Registration Card; ☐FL Court Filed Declaration of Domicile; ☐Utility Bill; ☐Mortgage or Lease Agreement; ☐Employment/School Record

10. Eligibility Assessments:

Do you agree to participate in assessment(s) that may be needed to find out if you are eligible for services provided by APD?

☐YES ☐NO

Assessment Needed (to be filled out by APD Staff):

____

____

11. APD Eligibility Determination (to be filled out by APD Staff):

Eligible for APD: __________ Date: __/__/____

Eligibility Category: ____________________

Not eligible Date: __/__/____

Reason: ____________________

12. Collateral/Supporting Information or Source of Information About Disability (to be filled out by APD Staff):
(IQ scores, medical records, school records, etc.)

13. Waiver Eligibility Determination (to be filled out by APD Staff):

Eligible for Medicaid Waiver: Date: __/__/____

Not eligible Date: __/__/____

Reason: ____________________

14. ICF Eligibility Determination (to be filled out by APD Staff):

Eligible for ICF: Date: __/__/____

Not eligible Date: __/__/____

Reason: ____________________

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15. By signing this application, I understand and acknowledge that it is my responsibility to keep the Agency informed of any changes in address or telephone number so that I may be contacted immediately if the Agency has any questions about my application, or, if I am deemed eligible for services if services have become available. Failure to keep the Agency informed of how I may be contacted may result in my application not being processed, or if determined eligible for services, my active client status being closed. Further, if my name has been added to the Medicaid HCBS Waiver Wait list, it will be removed. In the event the Agency is not able to contact me by mail or phone, I authorize the Agency to contact the following person, who does not live at my address:

ALTERNATE CONTACT:

Name: ______________________________ Phone: ______________

Address: ____

Relationship to Applicant: ______________ E-mail: ______________

16. ALL INFORMATION PROVIDED ABOVE IS COMPLETE AND ACCURATE, TO THE BEST OF MY KNOWLEDGE.

Signature of Applicant: ______________________________ Date: __________

Signature of Legal Representative: ______________________________ Date: __________
For application for government benefits or for making medical decisions

Printed Name of Legal Representative: ______________________ Relationship: ______________

Signature of Person Assisting the Applicant (if applicable): ______________________ Date: __________

17. Referrals (to be filled out by APD Staff):

To	Date	Contact	Address/Telephone #

I have received a copy of:

- ☐ The Bill of Rights of Persons who are Developmentally Disabled, section 393.13, Florida Statutes.
- ☐ Family Care Council Brochure
- ☐ Serving Floridians with Developmental Disabilities - brochure
- ☐ Agency for Persons with Disabilities Guide to Administrative Hearings- brochure
- ☐ HIPAA Notice of Privacy Practice

YOU CAN APPLY TO REGISTER TO VOTE HERE

If you are not registered to vote where you live now, would you like to register to vote here today? Check YES if you would like to apply to register to vote or update your voter registration information. If you check the NO box or do not check a box, you will be considered to have decided not to apply to register to vote or update your voter registration information. Checking YES, NO, or leaving this question blank will not affect your receipt of benefits.

☐ YES ☐ NO

NOTICE OF RIGHTS

Help: If you would like help in filling out your voter registration application, we will help you. The decision whether to seek or accept help is yours. You may fill out the voter registration application in private.

Benefits: If you are applying for public assistance from this agency, applying to register, or declining to register to vote will not affect the amount of assistance you will be provided by this agency.

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Privacy: Your decision not to register or update your record and the location where you applied to register or update your voter registration record is confidential and may only be used for voter registration purposes.
Formal Complaint: If you believe someone has interfered with either your right to apply to register or to decline to register to vote, your right to privacy in deciding whether to apply to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with: Florida Secretary of State, Division of Elections, NVRA Administrator, R.A. Gray Building, 500 S. Bronough Street, Tallahassee, Florida 32399-0250. Forms for filing a complaint are available at http://election.dos.state.fl.us/nvra/index.shtml

* The collection of social security number is for record keeping purposes and is imperative to the agency's duties and responsibilities as prescribed by law. The social security number collected will not be available to the general public.

FILL-IN INFORMATION REQUIRED FOR VERIFICATION OF NON USA BORN CITIZENS/IMMIGRANTS

DOCUMENT TYPE	ALIEN/ USCIS/INS NUMBER "A" followed by 7,8, OR 9 numbers	CARD NUMBER 3 letters followed by 10 numbers Ex. ABC0000000000	I-94 NUMBER 11 digit number Ex. 000 00000000	PASSPORT NUMBER 6 to 12 digits with alpha-numeric characters	EXPIRE DATE	COUNTRY OF ISSUANCE	CERTIFICATE NUMBER 8 digit number Ex. 00 000 000	SEVIS ID "N" followed by 10 digit number Ex. N0000000000	NAME OF DOCUMENT
I-551 (Permanent Resident Card)									
Certificate of Citizenship									
Naturalization Certificate									
Unexpired Foreign Passport									
I-571 (Refugee Travel Document)									
DS2019 (Certificate of Eligibility for Exchange Visitor (J-1) Status)									
I-20 (Certificate of Eligibility for Nonimmigrant (F-1) Student Status)									
I-327 (Reentry Permit)									
I-766 (Employment Authorization Card)									
I-94 (Arrival/Departure Record)									
I-94 (Arrival/Departure Record) in Unexpired Foreign Passport									
Machine Readable Immigrant Visa (with Temporary I-551 Language)									
Temporary I-551 Stamp (on passport or I-94)									
Other (Select if Document Not Listed)									

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AGENCY FOR PERSONS WITH DISABILITIES

Client Information Sheet

Date:	
Primary Disability:	
Secondary Disability:	
Referral Date:	
Referred By:	
Area of Residence:	
Insurance/ Resources: (Please complete)	
Health Insurance Company:	
Policy #:	
Medicare #:	
Medicaid #:	
Military Benefits:	
Income Amount: SSI SSA: Other	
Other Resources:)	

Name:							
SSN:		County					
Address:							
Phone #:	Day:		Evening:				
Email:							
TDD (Telephone Device for Deaf)							
DOB:		Age:		Male:		Female	
Legal Status:							
Guardian Type/ Area:							
Directions to Home:							

Background and Personal Information

Other Names/ Nick Names:								
Primary Language In Home:								
Are Interpreter Services Needed?	☐ Yes		☐ No					
If yes, what kind or language?								
Available Transportation:	None		Self		Bus			
Taxi		Family		Walk		Volunteer		
Other(Specify):								

Place of Employment

Employer:		
Address:		
Phone #:	Ext.	

Name:	
SSN:	

People to Contact		
Relationship	Name/Address	Phone #/Email
Guardian		
Mother		
Father		
Other Relatives		
Friends		

Programs/ Agencies Involved with Individual/ Family (include health care providers)			
Agency/Program:			
Contact Person:		Phone Number:	
Address:			
Agency/Program:			
Contact Person:		Phone Number:	
Address:			
Agency/Program:			
Contact Person:		Phone Number:	
Address:			
Agency/Program:			
Contact Person:		Phone Number:	
Address:			
Agency/Program:			
Contact Person:		Phone Number:	
Address:			

Additional Information:			
		Area	
		Contact Person:	
		Phone Number:	
Name/Title of Person Completing This Form:		Support Coordinator:	
Name:		Name:	
Title:		Phone Number:	

SOCIAL SERVICE INFORMATION QUESTIONNAIRE

Applicant's Name: ______________________ SS#: ______________

Applicant's School History

Name of School	Address	Date

Were you ever in special classes in school? ________ If so, why? ______________________
____
____

Applicant's Medical History

Current Physician: ______________________ Phone: ______________

Address: ____

Medical Problems including sensory deficits: ______________________
____
____
____

President Medication:	Dosage:	Prescribed by:	Reason Given:

MANAGEMENT AND PROTECTION OF
PERSONAL HEALTH INFORMATION POLICY

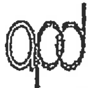
I hereby acknowledge receipt of the pamphlet
Your Privacy is important to us.

I understand that if I would like a copy of the complete APD Management and Protection of Personal Health Information Policy, one will be provided to me.

PRINT NAME: ______________________________

SIGNATURE: ______________________________

DATE: ________________



agency for persons with disabilities
State of Florida

Agency for Persons with Disabilities

Consent to Obtain or Release Confidential Information

Individuals Name:		Date of Birth

☐ **Permission for Obtaining Record Information.** I hereby give my permission and consent to the Agency for Persons with Disabilities or its representative to obtain the specified protected health information on the above named consumer from agencies, individuals and institutions identified below OR

☐ **I hereby request the specified protected health information on the above named consumer be sent to me OR**

☐ Permission for Release of Information. I hereby give my permission for the Agency for Persons with Disabilities or its representative to discuss matters related to my services or goals or to release protected health information to the following person, agency or institution.

The information requested below will be used/disclosed for the following purposes:

	Medical Reports		Social Service Reports
	Academic Records and Plans		Speech and Hearing Reports
	Habilitation Plans/Support Plans		Physical Therapy Reports
	Psychological Reports		Occupational Therapy Reports
	Other (Please specify):		

Name, address, or fax # of individual or agency from whom information is to be obtained:

Name, address, or fax # of individuals or agencies to whom information is to be provided:

1. **I understand that information may only be re-released with my approval except as required by law. However, I understand that if the receiver of the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations.**

2. **I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain services or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization.**

3. **I understand that I may revoke this authorization in writing at any time by contacting my support coordinator, except when the requested information has already been sent, based on this authorization.**

4. **I certify that I understand the above statements either personally or through my legal representative.**

5. **I also understand that this form is valid for no longer than 90 calendar days unless otherwise indicated. I understand that I may specify that it be for a shorter period of time.**

Expiration date: ____________________

Signature of Client or Legal Representative | Printed Name/Relationship to client | Date

If this authorization has been signed by a personal representative (above) on behalf of an individual, his/her authority to act on behalf of the individual must be set forth here:

____