Arlington Department of Human Service
Clinical and Developmental Services Department
2100 Washington Blvd., 4th Floor.
Arlington, VA 22204

Arlington County Developmental Services Eligibility Criteria and Checklist

Eligibility Criteria

Developmental Services are planned, individualized, person-centered services and supports that are provided to individuals with developmental disabilities for the purpose of supporting them to increase their self-determination and independence, obtain employment, participate fully in all aspects of community life, advocate for themselves, and achieve their fullest potential to the greatest extent possible.

To be eligible for Developmental Services, an individual must have a DD diagnosis according to the Code of Virginia (*§ 37.2-100*).

A developmental disability is a severe, chronic disability of an individual that:

i. Is attributable to a mental or physical impairment, or a combination of mental and physical impairments, other than a sole diagnosis of mental illness;
ii. Is manifested before the individual reaches 22 years of age;
iii. Is likely to continue indefinitely;
iv. Results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency; and
v. Reflects the individual's need for a combination and sequence of special interdisciplinary or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated.

An Intellectual Disability (ID) is a disability, originating before the age of 18 years that is characterized concurrently by:

i. Significant subaverage intellectual functioning as demonstrated by performance on a standardized measure of intellectual functioning, administered in conformity with accepted professional practice, that is at least two standard deviations below the mean, and
ii. Significant limitations in adaptive behavior as expressed in conceptual, social, and practical adaptive skills.

Eligibility Checklist: What is a complete packet?

What do I need?	What is it?	Why do I need it?	Do I have it?
Signed application for Developmental Services	8-page document that asks for demographic, medical, and social development information about the individual applying for services.	Developmental Services needs information about the applicant to determine eligibility for services.	☐ Yes ☐ No
Proof of Arlington residency (i.e., lease, utility bill, ID/driver's license, current school records, etc.)	Documentation supporting the applicant's name and current (Arlington) residential address.	To be open to services in Arlington, proof of County residency is required.	☐ Yes ☐ No
Records showing a qualifying disability in the developmental years (*birth to age 22 (age 18 for ID)*)	Documents by a school, psychologist, and/or doctor that shows the applicant has a developmental disability according to the Code of Virginia (*§ 37.2-100*)	Developmental Services needs to know if the applicant has a qualifying developmental disability diagnosis such as Autism Spectrum Disorder, Cerebral Palsy, Down Syndrome, Intellectual Disability (ID).	☐ Yes ☐ No
School evaluation documents, if applicable	A report showing observations and tests that helps staff determine if the applicant needs extra help or resources in school. A document showing how the school will meet the applicant's need(s) such as an Individual Education Plan (IEP) or psychoeducational report	This documentation may help to determine substantial limitations in adaptive functioning in the areas of self-care, receptive & expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency.	☐ Yes ☐ No
Documents determining legal responsibility/guardianship, if applicable	Court-issued or legal document showing who has the right to make legal decisions for an adult age 18 and older. A parent may make legal decisions for youth age 17 and younger.	Developmental Services needs to know who has the right to make legal decisions about the applicant.	☐ Yes ☐ No

To apply for services, return the completed application and documentation supporting the DD diagnosis:

By Mail to: Department of Human Services | Developmental Services
2100 Washington Blvd, 4th floor, Arlington, VA 22204

By E-mail: DS@arlingtonva.us

By Fax: (703) 228-1148

For questions or additional information, call and speak with the Developmental Services Duty Worker at (703) 228-1700 Monday – Friday between 9:00am and 4:30pm.

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 DEVELOPMENTAL SERVICES STAFF:
XII. CLIENT SUPPORT COORDINATION
Date application was received:
Name of DS Staff Processing Application:
Assigned Welligent ID#: