New Beginnings Enterprises, Inc.
Community Developmental Disability Organization
for
Chautauqua, Elk, Greenwood and Wilson Counties

Application for Mental Retardation and/or Developmental Disability Determination

General Information

Name:_____________________________________ D.O.B.:_________________________________

Address:___________________________________ S.S.N:__________________________________

___________________________________ Sex:_____________________________________

Telephone Number:__________________________ County of Residence:_____________________

Disabilities	Location of verification of condition	Age of onset

Legal Status

Check all that apply:

- ☐ Ward of the state
- ☐ Conservator
- ☐ Representative Payee
- ☐ Guardianship (court appointed)
- ☐ Limited Guardianship
- ☐ Power of Attorney

If you mark any above please complete below and attach documentation.

Name:____ Name:____

Address:_______________________________________ Address:_______________________________________

____ ____

Day telephone number:__________________________ Day telephone number:________________________

Name:____ Name:____

Address:_______________________________________ Address:_______________________________________

____ ____

Day telephone number:__________________________ Day telephone number:________________________

Have you ever resided in an institution? ☐ Yes ☐ No

Name and location ____

Financial Information

What are your financial resources?

☐ None ☐ Support from family ☐ Social Security
☐ Employment ☐ Supplemental Security Income (SSI) ☐ Other

Educational History

Currently attending high school? ☐ Yes ☐ No Special Education? ☐ Yes ☐ No

Graduated?________________ Year of Graduation?_________________

Name of last school attended:____

List all high schools attended:____

Service Information

If services were offered within the next three (3) years would you accept them? ☐ Yes ☐ No

If found eligible do you wish for your name and address to be released to community service providers who are affiliated to provide the services identified as needed by the CDDO staff? ☐ Yes ☐ No

Signatures

By signing below, I agree that the information contained in this application is correct to the best of my knowledge. I understand that falsification of information on this form may be cause for denial or rejection from services and/or supports.

I understand this application does not guarantee eligibility criteria for services for the Mentally Retarded and Developmentally Disabled. Nor does it guarantee funding for services if it is determined that I meet MR/DD eligibility.

____ ____________________

Applicant Signature Date

____ ____________________

Guardian Signature Date