Application for Determination of Eligibility for Children Under Age 18 with Developmental Disabilities

Form A: Applicant Information and Declaration

This form gathers information about the child and the child's benefits, education, and services. It also collects information on the individual submitting the application on behalf of the child.

The first part of this form must be signed by the individual who is submitting the application for the child. This must be the parent, legal guardian, or other individual legally allowed to do so.

You may gather information and get help with filling out this application from a friend, a family member, the child's school or doctors, or any organizations that help families get services.

State of New Jersey - Department of Children and Families
Declaration

In accordance with the Revised Statute, State of New Jersey, Section 30:4-25.2 and Section 30:4C-4.4, application is being made to the Commissioner of the Department of Children and Families for a determination of eligibility for services provided through the Division of Children's System of Care (CSOC) for:

Name: _____ _____ _____
First Name Middle Initial Last Name

Date of Birth: _____

By signing this application, I am also declaring that:

1. The Applicant, and/or his or her parent or legal guardian is a resident of New Jersey for other than temporary purpose and has expressed an intention to have his or her primary residence in the State in accordance with N.J.A.C. 10:196
2. This Application and all forms submitted along with it are completed as accurately as possible
3. I understand that I have the opportunity to appeal a determination of ineligibility in accordance with N.J.A.C. 10:196-5.1,and
4. I understand that if the Applicant is found eligible for CSOC services and requests out of home services, he/she will be required to provide all financial information in accordance with N.J.A.C.10:46D before out of home services will be provided.

This application is being made under the R.S. 30: 4-25.2 by virtue of the relationship to the Applicant indicated above:

☐ Parent ☐ Legal Guardian of minor (child)

☐ Court having jurisdiction over a minor ☐ Agency with custody of and caring for a minor

Signature: _____ **Date:** _____

Name:_____

Title, if Agency or Court representative: _____

SECTION 1: CHILD INFORMATION AND CITIZENSHIP STATUS

Instructions: Please fill out the following information about the child. Please note that you must provide proof that the child or the child's parent/legal guardian is a US citizen or permanent resident in order to apply.

Child's Name: _____ _____ _____
First Name Middle Initial Last Name

Child's Address: _____ _____
Street Apt Number

_____ _____ _____
City State ZIP

Gender: ☐ Male ☐ Female **Date of birth** *(mm/dd/yy)*: _____

Is the child a U.S. Citizen? ☐ Yes ☐ No

IF NO:

Expiration Date of permanent residency *(mm/dd/yy)*: _____

Does the child currently reside in a residential program? ☐ Yes ☐ No

IF YES, please complete below:

Placement Type: _____

Provider Name and Location: _____

Funding Source:_____

Date of Placement *(mm/dd/yy):*_____

Describe current living situation: _____

_____

_____

Is the youth currently involved with the DCP&P (Division of Child Protection and Permanency)?

☐ Yes ☐ No

Child's Primary Language: ☐ English ☐ Spanish ☐ Other:_____

Optional:

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino

Race: ☐ White ☐ Black or African American ☐ American Indian or Alaska Native
☐ Asian ☐ Native Hawaiian or Other Pacific Islander

SECTION 2: PARENT OR LEGAL GUARDIAN'S CITIZENSHIP, RESIDENCY STATUS AND CONTACT PREFERENCE

Instructions: This section of the application collects information about the person filling out the form, contact preferences, and whether you have an advocate or someone else helping you to complete the application. Note that this application must be submitted by an individual with the legal authority to do so (the individual indicated in the declaration), but you are welcome to have someone help you.

Please indicate who is submitting this document for the child:

☐ Parent ☐ Legal Guardian ☐ Division of Child Protection & Permanency (DCP&P)

Name: _____ _____ _____
First Name Middle Initial Last Name

Address: _____ _____
Street Apt Number

_____ _____ _____
City State ZIP

Primary Telephone: _____ Alternate Telephone: _____

Preferred telephone number for contact: ☐ Primary ☐Alternate

Court/Agency applicant only: Is the child's address and parent/legal guardian's address the same?

☐Yes ☐ No

If no, please supply the parent/legal guardian address below:

Address: _____ _____
Street Apt Number

_____ _____ _____
City State ZIP

Answer these questions based on the parent or guardian's status:

Is the child's parent or legal guardian a U.S. citizen or permanent resident? ☐Yes ☐ No

Is the child's parent or legal guardian a resident of NJ? ☐Yes ☐ No

You must submit proof of the parent/legal guardian's NJ residency. Proof of citizenship is only required for the parent or the child, not both.

In case there are any questions about your application, what is your preferred method for being contacted?

☐ Mail ☐ Telephone

Best time to call: ☐ Morning ☐ Afternoon ☐ Evening

Do you have a doctor, therapist, care manager or community services agency that is assisting you in completing this application? ☐Yes ☐ No

If yes, please provide organization name and details below:

Name: _____

Organization:_____

Primary Telephone: _____

Address: _____ _____

Street Apt Number

_____ _____ _____

City State ZIP

This section is intentionally left blank and is reserved for future use.

SECTION 3: CHILD'S CURRENT INSURANCE AND BENEFITS INFORMATION

1. Child's current health insurance (select all that apply):

☐ NJ Family Care Membership number: _____

☐ NJ Medicaid Membership number: _____

☐ Medicare Membership number: _____

☐ Private Insurance Policy Name: _____

Policy Number: _____

☐ No insurance

***IF NO INSURANCE*:**

1A. Has the child ever been denied for private health care insurance in the past?
☐Yes ☐No

1B. Has the child ever been denied Medicaid coverage?
☐Yes ☐No

1C. Has an application for Medicaid been made for this child within the past 12 months?
☐Yes ☐No

1D. Do you plan to apply for insurance for this child within the next 3 months?
☐Yes ☐No

2. Does the child currently receive Social Security Disability or SSDI?

☐Yes ☐No

IF YES:

Claim Number: _____ Amount received per month: $ _____

IF NO:

☐ Never Applied ☐ Application Pending ☐ Ineligible

3. Do you plan to apply for Social Security benefits for this child within the next 3 months?

☐Yes ☐No

4. Does the child currently receive Supplemental Security Income (SSI) benefits?

☐Yes ☐No

IF YES:

Claim Number: _____ Amount received per month: $ _____

IF NO:

☐ Never Applied ☐ Application Pending ☐ Ineligible

If applicant receives SSA/SSDI or SSI, is there a Representative Payee?

☐Yes ☐No

IF YES, please complete below:

Benefit	Name	Address	Phone	Relationship
#1				
#2				

Comments:

SECTION 4: HEALTH CARE AND TREATMENT

Instructions: The presence of a disability or a disabling medical condition that requires ongoing services or supports is one of the requirements for Developmental Disability Services. In this section, identify the health care professionals who currently or recently have treated the child. Also include information about professionals who have provided diagnostic or treatment planning, going back up to three years ago if more recent diagnostic reports are not available.

1. Does the child currently have a primary care doctor (PCP)? ☐ Yes ☐ No
2. Has the child seen or have you had a visit to consult or get a diagnosis from a specialty care doctor such as a neurologist, psychiatrist, orthopedist, or other professional? ☐ Yes ☐ No
3. If yes, what is your child's current diagnosis?_____
4. Does the child require services for:

☐ Speech/Language ☐ Physical Therapy ☐ Occupational Therapy ☐ Counseling
☐ None ☐ Other:_____

5. Please list the name of the doctors or therapists who have most recently treated, prescribed or diagnosed the child:

Check	**Physician or Therapist Name/Group**	**Date Last Seen** (month/year)
☐	Primary Care	
☐	Specialty Care Doctor	
☐	Other Specialty Care Doctor	
☐	Speech/Language Therapist	
☐	Physical Therapist	
☐	Occupational Therapist	
☐	Counseling	
☐	Other	

SECTION 5 EDUCATION

Instructions: Please provide information about the child's current school, grade level, and educational classification, as appropriate.

1. Current School Enrolled

_____ _____ _____

Name City Township

2. Current Grade Level: _____

3. Current School Placement

- ☐ Mainstream classroom
- ☐ Resource Room
- ☐ Self-contained in regular school
- ☐ In-District Specialized School
- ☐ Special Services Unit
- ☐ Out-of-District school (day program only)
- ☐ Out-of-District school (residential)

4. Is the child classified by the Child Study Team?

☐ Yes ☐ No ☐ Waiting for determination ☐ Child not in school

IF YES

Date of initial classification (mm/year):_____

Grade Level at classification: _____

5. Current NJ Special Education Classification *(if applicable)*

- ☐ Auditorily impaired
- ☐ Autistic
- ☐ Pre-school child with disability
- ☐ Emotionally disturbed
- ☐ Multiply disabled
- ☐ Deaf/blindness
- ☐ Specific learning disability
- ☐ Orthopedically impaired
- ☐ Cognitively impaired
- ☐ Communication impaired
- ☐ Socially maladjusted
- ☐ Traumatic brain injury
- ☐ Visually impaired
- ☐ Other health impaired

Comments:

Important! This is the first part of a four part application. Please continue to Form B: Child Adaptive Behavior Summary (CABS).