



Andrew J. Spano
County Executive

Department of Community Mental Health
Grant E. Mitchell, M.D.
Commissioner

Dear Consumer/Parent/Advocate:

Welcome to the Westchester County Department of Community Mental Health, Developmental Disabilities Services Office. Our goal is to assist you access appropriate services. Enclosed is the Developmental Disabilities Registration and Consent to Release Information forms. Please complete as much of the registration form as you can. You may leave some questions blank if you do not have the information or are uncertain.

The Registration form in itself is not sufficient for eligibility determination. In addition, you will need to include the following documentation and/or reports which are required to determine eligibility:

- A full scale psychological evaluation, completed within the last 3 years, establishing IQ
- An adaptive behavior scale such as the Vineland II or the ABAS II
- A psychosocial report, social history or other background report that indicates that the disability occurred before the age of 22
- A physical evaluation completed within the last year, including diagnosis
- Any specialty reports relevant to the individual (neurological, psychiatric, etc.)
- Treatment summaries or reports from any previous or current psychiatric hospitalizations
- Any previous evaluations referenced in the above documentation (i.e. a previous psychological evaluation)
- Current IEP or Pre-school evaluations

Please note that while this office will assist you through the eligibility process, it is your responsibility to gather all the required information, as we do not solicit or request information for eligibility determination. Please forward these and any other evaluations that would assist us in completing an eligibility packet to my attention. This information will be submitted to the Hudson Valley Developmental Disabilities Services Office to determine eligibility to apply for services. Services cannot be applied for and or approved until eligibility has been established. If you have any questions, please contact me at 995-5257.

Sincerely,

José E. De Jesús, M.P.A.
Program Coordinator – Developmental Disabilities Services



Developmental Disabilities Registration

Date: _____

Consumer's First Name: _____ Last Name: _____

Current Address: _____ Zip Code: _____

Date of Birth: ____ / ____ / ____ Age: ____ Medicaid #: _____ S.S.# ____ - ____ - ____ SSI/D? _____

Private Insurance: Y/N Company/Policy #: _____

Disability Information (Please check all that apply:)

I.Q: _____ Level of Mental Retardation: Mild: _____ Moderate: _____ Severe: _____ Profound _____

Epilepsy/Seizure disorder _____ Cerebral Palsy _____ Autism _____ Neurological Impairment _____

Orthopedic Impairment: _____ Emotional Disability: _____ Other: _____

Circle

Ambulatory: (Y/N) Ambulation Problems: _____

Correspondent's Name: _____ Relationship : _____

Address: _____ Zip Code: _____

Home Phone: () _____ - _____ Work Phone: () _____ - _____

School or Day Program: _____ Program Contact _____

Program Address: _____ Phone: () _____ - _____

Program City and State: _____

Does consumer require residential assistance? Y / No When?: _____

Does consumer need support in the home? Y / No What service are your seeking? _____

General Comments: _____



DEPARTMENT OF COMMUNITY MENTAL HEALTH
 112 East Post Road, White Plains, New York 10601 (914) 995-5244

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I hereby authorize the release of information from the records of:

To the Westchester County Department of Community Mental Health, 112 East Post Road, White Plains, New York, 10601 for the purpose of arranging needed services. I understand this authorization does give Westchester County Department of Community Mental Health the authority to release said information when there is a need to arrange services on behalf of the above named client.

I understand that I may revoke this consent at any time.

 Consumer's Signature

 Signature of person authorized to act on
 behalf of the consumer

 Consumer's Address

 Relationship of authorized person

 Address of authorized person

Witnessed by: _____
 Signature

 Address:

Date: _____