Developmental Disabilities Family Support Application Form

Mental Health Association in Orange County, Inc.
73 James P. Kelly Way, Middletown NY 10940

Phone-(845) 342-2400
Fax- (845)343-9665
Print additional forms at www.mhaorangeny.com

ATM ____ ASF ____ CAPIS ____

Date_____

Name of Applicant _____

Address_____

City_____ State_____ Zip Code_____ E-mail_____

Telephone _____ Birth date _____ Gender Identity: ☐ Male ☐ Female ☐ Prefer Not To Say/Other

☐ Transgender Male ☐ Transgender Female ☐ Nonbinary

Social Security Number _____-_____-_____ Tabs # _____

Referring service provider/Coordinator _____Agency_____

Phone _____E-mail _____

Parent/family contact name_____ Relationship_____

Telephone other than home_____ E-mail _____

Living with Parent/Guardian? Y_____ N _____ **Self Direction? Y _____ N _____**

Services requested (peer counseling, consultant services, financial request, etc.), and how it will benefit individual:

_____

_____

_____

If reimbursement requested, to whom will the check be made out:

Name_____Phone _____

Address_____

City_____ State _____ Zip _____

Have you made this request to any other program or service? Yes _____ No_____

Specify programs/services contacted_____

Outcome of services contacted _____

Additional information you want us to know about the request:_____

_____

_____

CLERICAL USE ONLY

Date Received _____ Date Processed _____

CHOICES _____ DDP1 Submission Date _____ Approved or Denied? _____ FH_____

Gift Card? Y _____ N _____ Pick Up Date _____

Additional Comments_____

Mental Health Association
in Orange County, Inc.
NADIA ALLEN, EXECUTIVE DIRECTOR

Financial Reimbursement Programs

ATM
In order for your **initial** Access to Money (ATM) Fund application to be processed you will need to submit items ***1 through 4.***

1) Completed application form, printed or typed clearly!

2) HIPAA ("Notice of Privacy Practice and Program Participants Rights" found on MHA's website) signature page filled out, signed and dated.

3) Proof of OPWDD eligibility: Notice of Decision (NOD) from Hudson Valley DDRO.

4) Invoice, receipts, price list or brochure for the services/goods requested and vendor contact information.

ASF
In order for your **initial** Autism Spectrum Fund (ASF) application to be processed you will need to submit items ***1 through 4.***

1) Completed application form, printed or typed clearly!

2) HIPAA ("Notice of Privacy Practice and Program Participants Rights" found on MHA's website) signature page filled out, signed and dated.

3) Verification of Autism Spectrum Disorder:
•A diagnostic report from a MEDICAL DOCTOR. Be aware that reports from psychologists, nurse practitioners or school psychologist will not be accepted!

or

•Notice of Decision (NOD) from Hudson Valley DDRO.

4) Invoice, receipts, price list or brochure for the services/goods requested and vendor contact information.

CAPIS
In order for your **initial** Crisis Assessment Prevention Intervention Service (CAPIS) application to be processed you will need to submit items ***1 through 3.***

1) Completed application form, printed or typed clearly!

2) HIPAA ("Notice of Privacy Practice and Program Participants Rights" found on MHA's website) signature page filled out, signed and dated.

3) A diagnostic report from a MEDICAL DOCTOR. Be aware that reports from psychologists, nurse practitioners or school psychologist will not be accepted!

73 JAMES P. KELLY WAY * Middletown, NEW YORK 10940 * (845) 342-2400-FAX (845) 343-9665
EBEN ROCKWELL HILL, PRESIDENT * A UNITED WAY AGENCY