Transmittal Form for Determination of Developmental Disability

Proof of a person's qualifying developmental disability is required in order to determine eligibility for OPWDD services. Complete this form and submit it to your local Developmental Disabilities Regional Field Office (DDRFO). (See Instructions on page 2).
UPLOAD: Copies of Records that are evidence of a disability prior to age 22 into CHOICES. Contact your local DDRFO if you have questions or need help filling out this form. An * indicates required information.

Section 1: Person's Information

*Last Name:			*First Name:		Middle Initial:
TABS ID (if known):	*SSN:		*Also Known As:		
*Date of Birth:	Medicaid #:		Sex Assigned at Birth: M ☐ F ☐ X ☐	Gender Identity:	
* Home Address:			Mailing Address (if different):		
*City:	*State:	*Zip:	City:	State:	Zip:
*County of Residence:					
*Phone:					
Email:					
Expected Graduation Date:					
*Preferred Written Language:					
*Preferred Spoken Language:					
Preferred Sign Language:					
Preferred Accessible Communication:					

***Send Information to:** (Check as many as desired)

☐ Self - Home Address ☐ Parent/Advocate 1 (Complete Section 2)

☐ Self - Mailing Address ☐ Parent/Advocate 2 (Complete Section 2)

Section 2: Involved Parents or Advocates (Optional – Unless Checked Above)

Parent/Advocate 1			Parent/Advocate 2		
Name:			Name:		
Mailing Address:			Mailing Address:		
City:	State:	Zip:	City:	State:	Zip:
Phone:			Phone:		
Email:			Email:		
Preferred Written Language:			Preferred Written Language:		
Preferred Spoken Language:			Preferred Spoken Language:		
Preferred Sign Language:			Preferred Sign Language:		
Preferred Accessible Communication:			Preferred Accessible Communication:		

Section 3: Referring Agency Information (Automatically receives information if completed)

Agency Name:				
Agency Code (If known):		Street Address:		
Agency Contact:				
Phone:	Email:	City:	State:	Zip:

Section 4: Services (Select the services you are interested in receiving if determined eligible)

☐ Developmental Disabilities Determination Only – No Services requested at this time

☐ Family Support Services (FSS): Other Family Supports

☐ Article 16 Clinic ☐ Care Management ☐ Environmental Modifications/Adaptive Devices ☐ Intermediate Care Facility (ICF)

☐ Children's Waiver ☐ Day Habilitation ☐ Family & Education & Training (FET) ☐ FSS: Respite ☐ Pre-Vocational Services

☐ Community Habilitation ☐ Day Treatment ☐ FSS: PASRR Level 11 Assessment ☐ Respite Center ☐ Supported Work (SEMP)

☐ Residential Habilitation (IRA)

FSS: Other (specify):

* Completed By (Name): *Date:

Following to be completed by DDRFO Staff Only:

Date Received by DDRO:	**Intake Staff Name:**	
Person's TABS ID #:	**Date entered in TABS:**	**By (initials):**

Instructions for Completing Transmittal Form

General Instructions:

Complete this form and upload the supporting documentation into CHOICES. Send an email to the CCO Alert Mailbox indicating that the documents have been submitted electronically and are ready for review. The supporting documentation will be used for the OPWDD eligibility review. If you have questions about the kinds of records needed for the eligibility review, see the ELIGIBILITY FOR OPWDD IMPORTANT FACTS and/or the APPLICATION CHECKLIST FOR DETERMINATION OF OPWDD ELIGIBILITY, both can be found on the OPWDD website opwdd.ny.gov or requested from your local DDRFO. **NOTE:** The Transmittal is **NOT** an application for services.

Detailed Instructions:

This Transmittal Form must be completed by staff at a Care Coordination Organization, Service Access Agency, a Local Government Unit or an OPWDD Specialty Liaison.

Section 1: Person's Information

Last Name/First Name/Middle Initial:	The person's legal last name, first name, and middle initial.
TABS ID:	The person's TABS Identification Number. If not registered, leave blank.
SS#:	The person's 9-digit Social Security Number.
Also Known As:	List all names (other than legal name) the person is known by, including nicknames, Maiden name. If no other names apply, leave blank.
Date Of Birth:	The person's date of birth, in month, day, year (MM/DD/YYYY) format.
Medicaid #:	The person's Medicaid number. If unknown, leave blank.
Sex Assigned at Birth:	Check the M box for Male, the F box for Female, or X for another gender.
Gender Identity:	Select the gender identity that applies to the person from the list of dropdowns.
Home Address:	The person's home address. Include the street, apartment number, city/town, state and zip code.
Mailing Address:	The address where the person receives mail, if different from the home address.
County of Residence:	The county in which the person resides (e.g., Albany, Essex, Kings).
Phone:	The person's phone number, including area code.
Email:	The person's email address. If the person does not have an email, leave blank.
Expected Graduation Date:	The date the person is expected to graduate. If not in school, leave blank.
Preferred Written Language:	The language in which the person prefers to read.
Preferred Spoken Language:	The language in which the person prefers to speak.
Preferred Sign Language:	The sign language in which the person prefers to use (e.g., ASL)
Preferred Accessible Communication:	Select the preferred accessible communication type that applies to the person from the list of dropdowns.
Send Information to:	Select the appropriate box indicating where the information about the person's eligibility decision should be sent. If a parent or advocate is to be sent information complete Section 2. The agency identified in Section 3 will automatically receive information concerning the person's eligibility determination.

Section 2: Involved Parents or Advocates – This section is optional unless selected to Send Information To is checked. Complete the Parent or Advocate 2 section if there is more than one Parent or Advocate involved.

Name:	The parent or advocate's name: last name, first name, and middle initial.
Mailing Address:	The address where the Parent or Advocate receives mail. Include street, apartment number, city/town, state and zip code.
Phone:	The Parent or Advocate's phone number, including area code.
Email:	The Parent or Advocate's email address. If none, leave blank.
Preferred Written Language:	The language in which the Parent or Advocate prefers to read.
Preferred Spoken Language:	The language in which the Parent or Advocate prefers to speak.
Preferred Sign Language:	The sign language in which the person prefers to use (e.g., ASL)
Preferred Accessible Communication:	Select the preferred accessible communication type that applies to the Parent or Advocate from the list of dropdowns.

Section 3: Referring Agency Information

Agency Name:	The agency's complete name.
Agency Code:	The agency's OPWDD agency code, if known.
Agency Contact:	Name of the agency staff person to be contacted about the eligibility determination.
Street Address:	The address where the agency contact receives mail. Include the PO box or street address, city/town and zip code.
Phone:	The agency contact's phone number, including area code and any extension.

Section 4: Services

Place an "X" in the first box for a determination of developmental disability only. Or place an "X" in the box next to each service the person is interested in receiving IF they are determined to be eligible for OPWDD services.

Completed by:	The name of the person who completed the form and the date when the form was completed.

Submit the completed form and required records to your DDRFO by uploading the documents to CHOICES and sending an email to the CCO Alert Mailbox.