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Date of Completed Application _____

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Request for Eligibility Determination

- The Request for Eligibility Determination form and interview does not guarantee eligibility and/or that services will be provided.

- **Bring form to intake interview. Please do not send ahead of time**

Prospective Client/Consumer Information:

Name: _____ DOB: _____

Current Living Arrangements: _____

Physical Address: _____ City: _____ State: _____ Zip: ____

Mailing Address: _____ City: _____ State: _____ Zip: ____
(if different than physical)

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Preferred method to be contacted: ☐Phone ☐Email

Sex: Male ☐ Female ☐ Soc. Sec. #: __ __ __ - __ __ - __ __ __ __

Primary Language: _____

Does prospective client/consumer require an interpreter: ☐Yes ☐No

Citizenship Status: _____ Race: _____

Primary Contact Information:

☐Prospective Client is Primary Contact

Name: _____

Address: _____ City: _____ State: _____ Zip: ____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Preferred method to be contacted: ☐Phone ☐Email

Who is completing the form?

Name: _____ Relationship _____

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Requested services:

☐Service Coordination
Provides Information and Referral for internal And external services (21+)

☐ Family Support
Services for anyone currently living with their family

☐ Vocational
Supports to obtain and maintain employment (21+)

☐Transition
High School transition- I&R for benefits, resources Etc. planning for services after high school (16-21)

☐Respite
Provides family a short-term break (3+)

☐Day Activities
Supports for personal care, social and community activity (21+)

☐Community Support
Hourly support (21+)

☐Recreation & Leisure
Resources to community and/or adaptive activities

☐Supported Employment
Ongoing support to obtain and maintain employment (21+)

☐Benefits Consultation
Referral and assistance with State and and Federal benefits

☐Representative Payee
Fiscal management of funds\ from Social Security and Medicaid

☐Residential Services
Supports for living outside the family home (21+)

☐Environmental Modification
Adaptation to home environment related to disability

Requested Services Notes

_____
_____
_____

Basis for Application:

If prospective client/consumer has been diagnosed with any of the following developmental disabilities, please check all that apply.

☐Intellectuel Disability ☐Down Syndrome ☐Epilepsy
☐Cerebral Palsy ☐Autism ☐Seizure Disorder
☐PDD (Pervasive Developmental Disorder)
☐Specific Learning Disability (please specify) _____
☐ Acquired Brain Disorder (please describe): _____

Other Relevant diagnosis or information (please specify)
☐Thought Disorder ☐Mood Disorder ☐Disruptive Behavior Disorder
☐Anxiety Disorder ☐Personality Disorder ☐Chronic Health Condition

Has prospective client/consumer ever applied for or received services from a developmental services agency in New Hampshire? ☐Yes ☐No

If yes under what name _____ When: _____

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If yes, please identify most recent area agency:

☐Region 1: Northern Human Services
☐Region 2: Pathways of the River Valley
☐Region 3: Lakes Region Community Services
☐Region 4: Community Bridges
☐Region 5: Monadnock Developmental Services
☐Region 6: Gateways Community Services
☐Region 7: Moore Center
☐Region 8: One Sky
☐Region 9: Community Partners
☐Region 10: Community Crossroads

Residential Supports:

Who does the prospective client live with?

☐Staff ☐Roommate (paid) ☐Roommate (unpaid) ☐Own family (paid)
☐ Own family (unpaid) ☐Home Provider ☐ Paid/Subsidized Neighbor
☐Unpaid Neighbor ☐None ☐Foster Home

Referral Information:

Who referred you to Gateways Community Services? Please check box and specify the agency

☐Early Supports and Services
☐Dept. of Health and Human Services
☐Mental Health agency
☐Friend/Relative
☐Primary Care Doctor
☐Hospital
☐Childcare
☐Town Welfare
☐Religious
☐Soup Kitchen
☐Rehabilitation Center
☐Parent/Self
☐Self
☐School

Agency: _____

Relationships:

(Check all the apply)

Contact 1:
☐Parent☐Legal Guardian☐Sibling☐Case Manager☐Other: _____

Name: _____
Address: _____City: _____State: _____Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Contact 2:
☐Parent☐Legal Guardian☐Sibling☐Case Manager☐Other: _____

Name: _____
Address: _____City: _____State: _____Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Contact 3:
☐Parent☐Legal Guardian☐Sibling☐Case Manager☐Other: _____

Name: _____
Address: _____City: _____State: _____Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Contact 4:
☐Parent☐Legal Guardian☐Sibling☐Case Manager☐Other: _____

Name: _____
Address: _____City: _____State: _____Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Educational/Employment/Training/Residential Facilities (Begin with most recent):

☐Educational ☐Employment/Training ☐Residential
Setting Name: _____Start Date: _____ End Date: _____

Address: _____City: _____State: _____Zip: _____

☐Educational ☐Employment/Training ☐Residential
Setting Name: _____Start Date: _____ End Date: _____

Address: _____City: _____State: _____Zip: _____

☐Educational ☐Employment/Training ☐Residential
Setting Name: _____Start Date: _____ End Date: _____

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Address: _____City: _____State: _____Zip: _____

Medical Providers:

Contact 1:
☐Primary Care Doctor ☐Specialty Type: _____
Name: _____

Organization Name: _____

Address: _____ City: _____ State: _____ Zip: ____
Office Phone: _____ Fax: _____

Contact 2:
☐Primary Care Doctor ☐Specialty Type: _____
Name: _____

Organization Name: _____

Address: _____ City: _____ State: _____ Zip: ____
Office Phone: _____ Fax: _____

Contact 3:
☐Primary Care Doctor ☐Specialty Type: _____
Name: _____

Organization Name: _____

Address: _____ City: _____ State: _____ Zip: ____
Office Phone: _____ Fax: _____

Contact 4:
☐Primary Care Doctor ☐Specialty Type: _____
Name: _____

Organization Name: _____

Address: _____City: _____State: _____Zip: _____
Office Phone: _____ Fax: _____

Medical Information:

Diagnosis: _____

List current medication and prescriber: _____
_____
_____

GATEWAYS COMMUNITY SERVICES

_____
_____

Allergies: _____

Adaptive equipment (Ex. glasses, wheel-chair, hearing aids, iPad, etc.) _____
_____

Hospitalizations (Medical and Psychiatric):

☐Medical ☐Psychiatric
Facility: _____ Admission Date: _____ Discharge Date: _____
Reason: _____
_____

☐Medical ☐Psychiatric
Facility: _____ Admission Date: _____ Discharge Date: _____
Reason: _____
_____

☐Medical ☐Psychiatric
Facility: _____ Admission Date: _____ Discharge Date: _____
Reason: _____
_____

☐Medical ☐Psychiatric
Facility: _____ Admission Date: _____ Discharge Date: _____
Reason: _____
_____

Evaluations and Assessments:

*Any evaluations listed below should be provided for eligibility determination.

Date of most recent:

Psychological assessment: _____

Functional Skills/Adaptive Behavior Assessment: _____

School evaluation _____

IEP/504 _____

Other (please specify) _____ Date_____

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Legal Issues

Include dates, description of incidents, arrests, competency hearing, which police department, time served, juvenile probation, CHINS, etc.

Psychiatric History

Include mental health treatment, therapists, residential placements, etc.

Significant behaviors

Other Relevant Information:

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GATEWAYS COMMUNITY SERVICES

Insurance Information (prospective client/consumer only):

Private Medical Insurance ☐Yes ☐No

Subscriber Name: _____

ID # _____

Medicare: ☐Yes ☐No Claim # _____

Medicaid: ☐Yes ☐No MID # _____

Managed Care Organization (MCO): ☐ New Hampshire Health Families ☐ Wellsense

Other Agencies Involved:

☐Bureau of Special Medical Needs
Contact: _____ Phone: _____

☐Gr Nashua Mental Health Center
Contact: _____ Phone: _____

☐NH Department of Health & Human Services
Contact: _____ Phone: _____

☐NH Vocational Rehabilitation
Contact: _____ Phone: _____

☐Bureau of Elderly and Adult Services
Contact: _____ Phone: _____

☐Division of Children, Youth & Families
Contact: _____ Phone: _____

☐Women's Infants Children (WIC)
Contact: _____ Phone: _____

☐ Vocational Rehabilitation
Contact: _____ Phone: _____