State of Illinois
Department of Human Services - Division of Developmental Disabilities

APPLICATION FOR INDIVIDUAL SERVICE AUTHORIZATION

Instructions: Use this application form to request individual service authorization for all services listed on this form (Page 2 of 3). Application is ***not*** required for respite services, Individual Service and Support Advocacy (ISSA), or grant-funded services.

SECTION A

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

Social Security Number _____ Recipient Identification Number _____

RIN/E-RIN

Birthdate _____

MM DD YYYY

Current Address _____

City _____ State _____ Zip Code _____ County _____

DHS/DDD Network: ☐ GIN-Central ☐ GIN-Northwest ☐ Metro Chicago North ☐ Metro Chicago North Suburbs
☐ GIN-North Central ☐ GIN-Southern ☐ Metro Chicago South ☐ Metro Chicago South Suburbs

SECTION B

Please answer each question below and supply all requested descriptive information. Attach additional pages if needed.

1. What is the individual's current living arrangement?
(check one)

- ☐ Private residence including supervision (such as family home).
- ☐ Private residence, living independently.
- ☐ DD community residential setting with supervision (e.g., CILA, CLF, SLA, Child GH).
- ☐ Private Intermediate Care Facility for Individuals with DD (ICFDD) including SNF/Ped.
- ☐ State-Operated Developmental Center (Specify which facility: _____).
- ☐ State-Operated Mental Health Center (Specify which facility: _____).
- ☐ Other (specify): _____).

2. If living in a private residence with supervision, what is the age of the primary care giver? _____ (fill in blank)

SECTION C

Please answer all questions below (check Yes or No) and supply all required descriptive information. Attach additional pages if needed.

1. ☐ Yes ☐ No Is the individual and/or the family currently receiving any government-funded services? If **yes**, please attach an explanation indicating the type(s) and amount(s) of service being received.
2. ☐ Yes ☐ No Is the individual in a crisis situation? If **yes**, please attach a description of the crisis situation, including but not limited to, individual has lost his/her caregiver, is in an abusive or neglectful situation, etc.
3. ☐ Yes ☐ No Is the individual a ward of the Department of Children and Family Services (DCFS)? If **yes**, please attach an explanation indicating the type(s) and amount(s) of service being received from DCFS.
4. ☐ Yes ☐ No Is the individual aging out of children's residential services funded by the Division of Developmental Disabilities?

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5. ☐ Yes ☐ No Is the individual a *Bogard* class member?
6. ☐ Yes ☐ No Is the individual attending special education?
7. ☐ Yes ☐ No Has the individual left special education within the last five years?
8. ☐ Yes ☐ No Is the individual living with only one caregiver?

SECTION D

Address of proposed residential placement (if applying for out-of-home residential supports):

Address _____

City _____ State _____ ZIP _____ County _____

SECTION E - See instructions below the table.

REQUIRED ATTACHMENTS

An (*) indicates attachments that must be submitted for each service requested. It is understood the Division of Developmental Disabilities reserves the right to request additional information as necessary to determine eligibility for funding for the requested services(s).

1	PROG CODE	PROGRAM DESCRIPTION	2 REQUESTED EFFECTIVE DATE OF PLACEMENT (MM/DD/YYYY)	IEP	SCHOOL CO-FUND LETTER	PUNS PRINT SCREEN	DD PAS 5 & 6	COPY OF MEDICAID CARD	COPY OF SSN CARD	PSYCHO-LOGICAL/ OTHER EVALUA-TIONS	NURSING SERVICE PACKET	INDIVIDUAL GUARDIAN INFORMA-TION DD FORM	DRS DENIAL OR TERM
	17D	Children's Group Home		*	*	*	*	*2	*	*1		*	
	19D	Residential School/ Child Care Institution		*	*	*			*	*1		*	
	31U	Developmental Training (DT)				*	*	*	*	*1		*	
	36G 36U 39G 39U	Supported Employment				*	*	*	*	*1		*	*
	67D	Community Living Facility				*	*	*	*	*1	*	*	
	CHBS	Children's Home-Based Support		*		*	*	*2	*	*1		*	
	AHBS	Adult's Home-Based Support				*	*	*	*	*1		*	
		Other (Specify) _____				*			*	*1		*	

Instructions:
1) Place an "X" by the program code(s) being requested.
2) Indicate requested placement(s) effective date(s).
3) Attach documentation indicated by a "*"

NOTES: *1 Psychological evaluation required if MR. Psychiatric evaluation and psycho-social assessment required if Autism. Physical evaluation required if other related condition.
2. If Medicaid eligibility has already been determined.

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RIN/E-RIN

SECTION F - Signatures

The provider and PAS signatures below confirm that the individual has a developmental disability and meets all other eligibility criteria, including the priority population criteria, for the requested service(s) and that this packet is complete and accurate. **Providers and PAS agencies should not make any commitments to an individual, guardian, or family member until they are in receipt of an original or carbon copy of Award Letter from the Division of Developmental Disabilities**. Please be aware that the Division will not reimburse for services delivered prior to the earliest effective date stated in the Award Letter.

Provider Name (if provider has been identified) _____ 4 Digit Identification Number _____ Provider FEIN _____

Provider's Contact Signature _____ MM/DD/YYYY _____

Provider Contact's Telephone Number (Include Area Code) _____ Extension _____ Provider Contact's E-Mail Address _____

PAS/ISSA Agency Name _____ 4 Digit Identification Number _____ PAS/ISSA Agency FEIN _____

PAS/ISSA Contact's Signature _____ MM/DD/YYYY _____

PAS/ISSA Contact's Telephone Number (Include Area Code) _____ Extension _____ PAS/ISSA Contact's E-Mail Address _____

Print Form Reset Form