**Robert P. Astorino**
**County Executive**

Department of Community Mental Health

Grant E. Mitchell, M.D.
Commissioner

Dear Parent, Guardian and/or Advocate,

Welcome to the Developmental Disabilities unit of the Westchester County Department of Community Mental Health (WCDCMH). Our office works closely with the Office for People with Developmental Disabilities (OPWDD) and serves as the single point of entry into the OPWDD system for Westchester County residents. Our office's goal is to assist you with the process for eligibility (which needs to be established before any services can be accessed), to provide information and resources, to connect you with vital community contacts, and to help you to access appropriate services that the individual may need now and for the future.

We ask you to please complete the registration and consent form and return it to our office. The Registration is only one part of the process. The other is the submittal of the documentation that the state requires in order for eligibility to be determined. Whether the parent, guardian, advocate or school submits the documentation, the following is required by the state to establish eligibility:

1). A current IEP from the school or school records if one has left the school system.
2). A **full- scale psychological evaluation** stating the full scale IQ within a three year period.
3). An Adaptive Behavior Test Measurement (i.e. Vineland II, ABAS II) which must include an interpretive report of each of the domains.
4). A complete social history report indicating disability occurred before the age of 22.
5). A **physical report** from a doctor within the year that you applying for eligibility.
6). Neurological, psychiatric, and/or hospitalization reports **if applicable** to the individual.

Once our office receives the above documentation, we will review the packet and submit the documentation to the Hudson Valley Developmental Disabilities Service Office (HVDDSO) who will then make a determination within a three month timeframe. They will contact you by mail once the determination has been made.

If you have questions or need further assistance please do not hesitate to contact us.

Sincerely,

Matthew Faulkner
Community Work Assistant

**Please submit your registration and/or documentation to:**
**Department of Community Mental Health**
**c/o Matthew Faulkner**
**112 East Post Road, 2nd Floor**
**White Plains, NY 10601**

*Revised 2/1/11*

112 East Post Road
White Plains, NY 10601
Telephone: (914) 995-5253
E-mail: mqf3@westchestergov.com

Westchester gov.com


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


***Developmental Disabilities Registration*** Date: ______________

Applicant's First Name: ________________________ Last Name: ________________________________

Current Address: ___________________________________________________Zip Code: _____________

Phone #( ) ____-_________ Date of Birth: _____/_____/_____ Age: ______ SS#____-____-____SSI/D? _____

Private Insurance: Y/N Company/Policy #:_____________________ Medicaid#: ______________________

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 or Mental Health Diagnosis ________________________
Other: _________________ Ambulatory (Y/N) Uses: Wheelchair____ Walker____ Crutches ____Orthotics____
Verbal (Y/N) Adaptive Devices

______________________________________________________________

Relationship of Correspondent (Check One) ☐ **Parent** ☐ **Legal Guardian** ☐ **Advocate**

Name: _____________________________________________

Address: ____________________________________________________________Zip Code: ________

Home Phone: ( ) ______ - ___________ Work: ( ) _____ - ___________ Cell: ( ) _____ - ___________

School or Day Program: _____________________________________ Program Contact _______________

Phone ( ) ______ - ______________ Anticipated Graduation Date: ___________________________

Address: ____________________________________________________________Zip Code: ________

Is Applicant Currently seeking services: (Check any that apply)

☐ In-Home Residential Habilitation ☐ Day Habilitation/Day Program ☐ Supportive Employment
☐ Medicaid Service Coordination ☐ Recreation Program ☐ Respite
☐ Individual Support Services ☐ Environmental Modifications ☐ Residential Opportunity
☐ Other (Explain) ______________________________________________________________________

Department of Community Mental Health
112 East Post Road, White Plains, NY 10601 914-995-5244

# CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

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

______________________________________
Consumer Name

To the Westchester County Department of Community Mental Health, 112 East Post Road, White Plains, NY 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 consumer

___________________________ Relationship of authorized person

___________________________

___________________________

___________________________ Relationship of authorized person

___________________________ Address of authorized person

Witnessed by: ___________________________
Signature

___________________________

___________________________
Address

Date: ___________________________