



# Request for Screening for the Developmental Disabilities Waiver

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Name of Person to be screened: (Please Print) \_\_\_\_\_

Home Phone (with area code): \_\_\_\_\_ Cell phone: \_\_\_\_\_

Check one:  Male  Female Date of application: \_\_\_\_\_

Address: \_\_\_\_\_

Street Address

\_\_\_\_\_

City	State	Zip
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Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_

Social Security Number \_\_\_\_\_

Please include with this request form any documentation which supports the current developmental disability diagnosis. Some examples of supporting documentation include:

- \_\_\_\_\_ Medical Documentation of Disability
- \_\_\_\_\_ Physician's Statement
- \_\_\_\_\_ Most Recent Psychological Evaluation, (+ IQ Scores)
- \_\_\_\_\_ All Available Psychological Reports
- \_\_\_\_\_ Most Recent Child Study Team or School Reports
- \_\_\_\_\_ Learning Evaluations/Social Summaries
- \_\_\_\_\_ Psychiatric Evaluation
- \_\_\_\_\_ Neurological Evaluation
- \_\_\_\_\_ Hospital Records/Discharge Summary
- \_\_\_\_\_ Physical Therapy /Occupational Therapy /Speech Therapy Evaluation



Does the person for whom you are requesting a screening have a diagnosis of an intellectual disability? Yes: \_\_\_\_\_ No: \_\_\_\_\_ Don't Know: \_\_\_\_\_

Name of parent/guardian (if applicable): \_\_\_\_\_

Name of person completing this form: \_\_\_\_\_

Email address of person completing this form \_\_\_\_\_

Signature of person completing this form: \_\_\_\_\_

Please fill out this form completely and, along with accompanying documentation, deliver to:  
1241 North Main Street  
Harrisonburg, VA 22802  
Attention: DD Services  
Or  
Fax to 540-432-0572