State of Vermont – DAIL
Developmental Disabilities Services
Application Form

Agency Applying to: _____
Date: _____

Services Requested for: _____
Address: _____ **Phone Number:** (___) ___-_____
_____
_____

Date of Birth: _____/_____/_____ **Social Security Number:** _____-_____-_____

Applicant's Name: _____
Address: _____ **Phone Number:** (___) ___-_____
_____ **Email:** _____
_____

Relationship of Applicant to Individual: ☐ **Self** ☐ **Guardian** ☐ **Family**
☐ **Agency** **(with person's/guardian's consent)**

Insurance:	**Yes**	**No**	**Policy Number**
VT Medicaid	☐	☐	_____
Medicare	☐	☐	_____
Other _____			_____

Legal Guardian: ☐ **Private** ☐ **Public** ☐ **None**
Guardian's Name: _____
Address: _____ **Phone Number:** (___) ___-_____
_____ **Email:** _____
_____

Intake Questions:	**Yes**	**No**
▪ **Do you believe you (or the person you are applying on behalf of) has a developmental disability (i.e., diagnosis of intellectual disability or pervasive developmental disorder/autism spectrum disorder)?**	☐	☐
▪ **Are you (or the person you are applying for) a resident of Vermont? You must live in Vermont with the intention of staying. In the case of a minor child, at least one custodial parent shall be a resident of Vermont.**	☐	☐
▪ **Are you (or the person you are applying on behalf of) in crisis and in need of immediate services?**	☐	☐

Signature of Person and/or Guardian _____ **Date** _____

Signature of Applicant (if different) _____ **Date** _____

Please return completed form to the designated agency for developmental disabilities services in your region of the state.