

George Latimer
County Executive

Department of Community Mental Health

Michael Orth, M.S.W.
Commissioner

Dear Parent, Guardian and/or Advocate,

Welcome to the Developmental Disabilities unit of the Westchester County Department of Community Mental Health (DCMH). Our unit works closely with the Office for People with Developmental Disabilities (OPWDD). Our goal is to assist you with the process of applying for OPWDD eligibility, provide you with information and resources, connect you with vital community contacts, and assist you to access appropriate services now or in the future.

Please note that eligibility within the OPWDD system is required prior to accessing OPWDD services. In order to be determined eligible for OPWDD services, please complete and submit to us the following:

1. Developmental Disabilities Registration form
2. Consent form
3. Eligibility Materials
 - A **current (less than 1 year old)** medical/physical report from the individual's Doctor. Please make sure that the report is signed and dated.
 - A **current full-scale psychological evaluation** (i.e. WAIS-V, WISC-V, WIPPSI, C-TONI-II, Leiter-R, Stanford-Binet 5, Kaufman series of intelligence, etc..) that states the individual's FSIQ. OPWDD **does not accept abbreviated test measurements (i.e. WASI).**
 - A **current adaptive behavior assessment** (i.e. Vineland 3 or ABAS 3) that is based on input from 2 people who know the individual well. If the individual is in school than a parent and a teacher and if the individual is out of school a parent/advocate and someone else who knows the individual well. The Psychologist will complete an interpretive report of the results from the survey of questions given to the 2 informants. PLEASE NOTE THAT OPWDD DOES NOT ACCEPT THE BASC-3 AS AN ACCEPTABLE TEST MEASURE OF ADAPTIVE FUNCTIONING.
 - A **current (with 1 year) psychosocial history** including birth and developmental history. The report must be written by a clinician (i.e. Social Worker or Psychologist). If there are prior social history reports other than the current one being requested, then please submit them as well.
 - A **current IEP** if applicable.

- Clinical information **completed prior to age of 22 documenting the presence of a qualifying condition in the absence of an intellectual disability** (i.e. neurological evaluation, genetic testing, developmental pediatric evaluation, imaging or EEG reports, comprehensive ASD-specific assessment). For an individual who is on the autism spectrum a comprehensive report from a specialist (i.e. Developmental pediatrician, Pediatric Neurologist, Psychiatrist, Psychologist) who not only states the individuals diagnosis but provides the reasons why the diagnosis was given; the specific symptoms/behaviors that the individual exhibits of the diagnosis; some developmental background of the diagnosis, and if there is more than one diagnosis which is primary. If this report is not available then an autism specific-assessment i.e. **ADOS** (autism diagnostic observation schedule) or **ADI-R** (autism diagnostic interview revised).
- **Current (less than 1 year) service related reports** (i.e. Speech, OT and PT) are not required but can provide good supporting documentation.

Once we receive the completed registration form and evaluations, we will submit the packet to OPWDD for determination. Once OPWDD makes a determination they will contact you directly by mail.

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

Sincerely,



Matthew Faulkner

Please submit your registration and documentation to:
Department of Community Mental Health
c/o Matthew Faulkner
112 East Post Road, 2nd floor
White Plains, NY 10601
(914) 995-5253 or mqf3@westchestercountyny.gov

Revised 02/21/2023

DEPARTMENT OF COMMUNITY MENTAL HEALTH
112 East Post Road, White Plains, New York 10601**Developmental Disabilities Registration**

Date: _____

Applicant's First Name: _____ Last Name: _____
Address: _____ Zip Code: _____
Phone () _____ - _____ Date of Birth: ____/____/____ Age: _____ SS# _____ - _____ - _____
SSI/D? _____
Private Insurance: Y/N _____ Medicaid#: _____

Disability Information (Please check all that apply:)

I.Q.: _____ Level of Intellectual Disability: 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: () _____ - _____

Email address: _____ if wanting correspondences via email.

School or Day Program: _____ Program Contact _____

Phone () _____ - _____ Anticipated Graduation Date: _____

Address: _____ Zip Code: _____

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

- ☐ Community Habilitation ☐ Day Habilitation ☐ Supportive Employment ☐ Day Treatment
☐ Care Management ☐ Recreation Program ☐ Respite ☐ FET
☐ Article 16 Clinic ☐ 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

Address of authorized person

Witnessed by:

Signature

Address

Date:
