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Applying For Services

NOTE: *In this document, the term "you" and "your" refer to the individual applying for APD services, regardless of whether the application is completed by the applicant themselves, a family member, or a caretaker. Throughout the process, the term "you" and "your" are used interchangeably to represent the applicant.*

Advancing Families and Individuals Needing Services (AFINS) has created this detailed guide to help you prepare and submit your application for services through the **Agency for Persons with Disabilities (APD)**. This guide is informed by our own experiences and the support we've provided to others going through the same process. Our goal is to help you avoid common challenges and make the application journey smoother.

You can apply for APD services online or in person. APD recommends applying online through their secure Online Application Service (OAS) as it's faster and reduces the likelihood of errors or delays. However, submitting a paper application, whether by mail or in person, can add a personal touch that may help your case stand out to a caseworker. If you choose to apply online, you'll need to create an APD online account.

APD has provided a well thought out online Quick Guide: Applying for APD Services to give you a high level view of the application process.

We strongly suggest attending our **AFINS workshop** for a review of your application and personalized guidance to help put your case in the highest pre-enrollment priority category. Visit our website to see our calendar for workshop dates. Alternatively, you can schedule an appointment at the **APD regional office in Wildwood** to complete the application process in person with the assistance of an APD caseworker. Their phone number is **(352) 330-2749**.

It is also important to keep a journal to document your application process for services. It helps you stay organized and track key details such as dates, contact names, and what was discussed or submitted. This record can be valuable if there are delays, denials, or if you need to follow up. It also helps ensure consistency when speaking with different agencies or support coordinators, making it easier to advocate for yourself or a loved one.

The steps for applying for APD services are the same regardless of the method you choose. To make the process easier, we've broken it down into **three (3) steps** and recommend completing them one at a time to avoid feeling overwhelmed.

- **Step 1 - Complete Forms:** To apply for APD services, you must complete the Application for Services and Consent to Obtain or Release Confidential Information. These forms are available online and in the appendix. Complete as much as you can on your own, and if you need help with the rest, you can attend the AFINS workshop or seek assistance from APD.

- **Step 2 - Collect Supporting Documentation:** Regardless of how you choose to apply for APD services, you will need to gather all supporting documentation to include:

  - **Proof of identity** (birth certificate, Social security card),

- **Proof of citizen or alien status** (US birth Certificate, US passport, certificate of naturalization/citizenship, green card, USCIS alien status and number),
- **Proof of residency** (Florida Driver's License or ID Card, Florida's Voter Registration Card, Florida's Court Filed Declaration of Domicile, Homestead exemption filing, mortgage or lease agreement, or employment/school records),
- **Proof of a developmental disability diagnosis** (medical records, school records, diagnostic evaluations, IQ tests, tests of adaptive functioning psychological evaluations, and general testing - find a comprehensive list of required documentation specific to your diagnosis here),
- **Military service member's Uniformed Services ID** (if applicable),
- **Written power of attorney or durable power of attorney** (if applicable),
- **Proof of Guardianship** (if applicable),

- **Step 3 - Include a Personal Narrative:** Write a one-page professional letter introducing yourself and sharing your personal story. Clearly state your purpose and emphasize your urgent need to be placed in the highest pre-enrollment priority category. Present your personal emotional story in a formal clinical tone, focusing on your eligibility and highlighting the immediate need for action.

What to Include in a Paper Application Packet

If you prefer to submit a paper application, prepare the items listed below and follow the suggested guidance provided.

Completed Forms

Complete these forms as best you can on your own, and if you need help with the rest, you can attend the AFINS workshop or seek assistance from APD.

- **Application for Services** (online and in the appendix)
- **Consent to Obtain or Release Confidential Information** (online and in the appendix)

Cover Sheet

> ***NOTE**: Attaching a recent photo to the cover sheet puts a face to your name, making you more memorable to those reviewing your application.*

- A one page document listing all materials included in the application and states your goal. It:
  - **Summarizes the Contents**: Clearly outlines all enclosed documents - including your formal service request, personal narrative, and fact sheet - while highlighting the applicant's urgent circumstances to support immediate placement in the highest applicable APD crisis category.

- **Clarifies your Intent**: Clearly states your goal, such as requesting disability services and supports, so your message is not missed or misunderstood.
- **Establishes Professionalism and Credibility**: A concise, organized cover sheet signals that you're serious, prepared, and thoughtful in your approach.
- **Makes Follow-Up Easier**: It includes your contact information in one place, making it easier for the caseworker to respond or ask questions.

Fact Sheet

- A concise one-page summary document that supports your case with relevant data and clarity. It should include quick, impactful facts about your disability issues.
    - Your personal information,
    - An overview of your disability,
    - An overview of your daily support needs and current situation.
    - Your requested action - emphasizing your critical and time-sensitive circumstances that warrant immediate assignment to the highest applicable APD crisis category.
    - Your contact information

Formal Letter

- A one page professional letter introducing yourself and telling your personal story while stating your purpose - highlighting your urgent need to be placed in the highest pre-enrollment priority category.
- Tells your personal emotional story with a formal clinical tone.
- Focuses on eligibility and stresses an immediate call to action.

Example Artifacts

Below are cover sheet, fact sheet and formal letter examples you can use to start your paper application.

Cover Sheet: Joe Doe

[Your Name]
[Your Street Address]
[City, State ZIP Code]
[Email Address]
[Phone Number]

[Date]

Florida Agency for Persons with Disabilities
4030 Esplanade Way, Suite 380
Tallahassee, FL 32399

Subject: Request for Disability Services and Supports

Enclosures:

- Application for Services
- Consent to Obtain or Release Confidential Information
- Brief fact sheet on Joe's daily support needs
- Personal Letter requesting assistance
- Joe Doe's summary of diagnoses and disabilities
- Supporting medical documentation (if available)

Notes:

Joe Doe is a 52-year-old man with Fragile-X Syndrome, significant cognitive disabilities, and profound supervision needs. Immediate action is requested to secure services necessary for his health, safety, and community integration. Your support is critical to avoid institutionalization and promote a person-centered, community-based life for Joe.

Fact Sheet: Joe Doe

Personal Information:
- **Name**: Joe Doe
- **Age**: 52
- **Diagnosis**: Fragile-X Syndrome
- **Cognitive Function**: Combined IQ of 56
- **Living Situation**: Lives at home with elderly parents (ages 73 and 76)

Disability Overview:
- Significant functional limitations in memory, judgment, decision-making, communication, and motor skills.
- Cannot read or write beyond basic words ("Mom," "Dad," "Men's Room").
- Requires 24/7 supervision for safety.
- Displays high anxiety and autistic behaviors, especially with disruptions in routine.

Daily Support Needs:
- **Activities of Daily Living**: Assistance with grooming, toileting, dressing, and managing sleep apnea equipment.
- **Instrumental Activities of Daily Living**: Transportation, managing finances, accessing medical care, and emotional support.
- **Behavioral Support**: To manage anxiety and prevent self-harm.
- **Support Needed for Employment**: Transportation and supervision at part-time job at Winn-Dixie.

Current Situation:
- **Natural Supports Are Not Sufficient** due to parents' serious health declines.
- **Risk of Institutionalization** is high without immediate services.
- Services are **Medically Necessary** to maintain Joe's **Health and Safety Needs** and **Community Integration**.

Requested Action:
- Immediate enrollment onto the **iBudget Waiver**.
- Development of a **Person-Centered Plan** tailored to Joe's unique needs.

Contact Information:
- [Your Name]
- [Phone Number]
- [Email Address]

Formal Letter: Joe Doe

[Your Name]
[Your Street Address]
[City, State ZIP Code]
[Email Address]
[Phone Number]

[Date]

Florida Agency for Persons with Disabilities
4030 Esplanade Way, Suite 380
Tallahassee, FL 32399

Subject: Urgent Request for iBudget Waiver Services

Dear Sir or Madam,

I am writing to respectfully request your urgent support in securing disability services for my son, Joe Doe.

Joe is a 52-year-old man with Fragile-X Syndrome, resulting in significant **functional limitations**, cognitive disabilities, autistic behaviors, and high anxiety. He requires continuous assistance with **activities of daily living**, **instrumental activities of daily living**, and **behavioral support**. He cannot read, manage finances, or safely navigate the community without constant **supervision**.

Joe lives with my husband and me. I am 73, and my husband is 76, with serious health challenges that now prevent us from meeting Joe's increasing **health and safety needs**. Our **natural supports are not sufficient**, and Joe is at serious **risk of institutionalization** if he does not receive community-based services.

Enrollment onto the iBudget Waiver is **medically necessary** to maintain Joe's **community integration**, safety, and dignity. He urgently needs a **Person-Centered Plan** that provides caregiver assistance, transportation, skill-building, and **support for employment/volunteer work**.

Joe is a **vulnerable adult** who deserves to continue living safely and meaningfully in the community he knows. I respectfully urge you to support immediate action to secure these essential services for him.

Thank you for your attention to this critical matter. I would welcome the opportunity to provide additional information if needed.

Sincerely,

[*Your Signature*]

[Your Printed Name]

Assembly Order

1. **Cover Sheet** (on top)
2. **Application For Service**
3. **Consent to Obtain or Release Confidential Information**
4. **Formal Letter**
5. **Fact Sheet**
6. **Supporting Medical Documentation**

Final Checklist

- ☐ **Cover Sheet** is updated with today's date and APDs' address.
- ☐ **Application For Service** is complete and accurate.
- ☐ **Consent to Obtain or Release Confidential Information** is complete and accurate.
- ☐ **Fact Sheet** is complete and accurate.
- ☐ **Formal Letter** is signed by hand (if possible to add a personal touch).
- ☐ **Medical documents** are neatly clipped (not stapled) and properly ordered.
- ☐ **All pages** have your contact information.
- ☐ **Make a full copy of everything** and save originals for your own records.
- ☐ **Journal** your progress.
- ☐ **Use a 9x12 envelope** (no folding) for a more professional presentation.
- ☐ **Mail it via Certified Mail with Return Receipt Requested** to get a proof of delivery (very important for official correspondence).

Deliver Your Message

- Hand deliver or mail your package to the Florida Agency for Persons with Disabilities.
- (Optional) Bring your package with you to meetings, advocacy days, or town halls.
- (Optional) Post pieces (especially your story and facts) on social media to raise awareness.

Follow-Up

- **Initial follow-up:** Wait about 2–3 weeks after submitting your application before your first follow-up.
- **Subsequent follow-ups:** If you don't hear back, follow up once every 3-4 weeks - unless APD gives you a different timeline.
- **Build a relationship** with your APD decision-maker or influencer.

Phone Follow-Up Script

Hello, my name is [Your Full Name].

I recently mailed a packet of information regarding urgent disability services for my son, Joe Doe.

I'm calling to confirm that APD received it and to see if there's any additional information I can provide to support the request.

I would be very grateful if APD could review our situation as soon as possible. Joe is at serious risk without support.

Thank you so much for your time and assistance today!

Email Follow-Up Template

Subject: Follow-Up on Disability Services Request for Joe Doe

Dear Sir or Madam,

My name is [Your Full Name], and I recently mailed a packet regarding my son, Joe Doe, requesting urgent assistance in securing disability services through the iBudget Waiver.

I am writing to kindly confirm whether the packet has been received.
Please let me know if any additional information or documentation is needed to assist with the review of our request.

Thank you very much for your time and consideration on behalf of Joe and our family.

Sincerely,
[Your Full Name]
[Your Phone Number]
[Your Email Address]

Quick Answers to Common Questions

- **Question:** Why is this urgent?

Say:
Joe is a vulnerable adult with serious functional limitations.

My husband and I, who are his only caregivers, are elderly and facing serious health challenges. We can no longer safely meet his health and supervision needs. Without services, Joe is at immediate risk of institutionalization.

- **Question**. What services exactly are you requesting?

Say: We are requesting enrollment onto the iBudget Waiver and the creation of a Person-Centered Plan.

Joe urgently needs caregiver support for activities of daily living, transportation to his part-time job and medical appointments, behavioral supports for anxiety, and skill-building to maintain his community integration.

- **Question**. Why can't natural supports handle this?

Say:
Natural supports — meaning me and my husband — are no longer sufficient due to our own serious medical limitations.

Joe's needs exceed what aging caregivers can safely provide. Services are medically necessary to prevent crisis and institutionalization.

- **Question**. What risk is there to Joe without services?

Say:
Joe is highly vulnerable without 24/7 supervision.

Without services, he could suffer exploitation, injury, severe anxiety, or hospitalization. Services will keep him healthy, safe, and active in the community.

Bonus Tips

- Stay polite and calm even if they seem rushed — persistence and professionalism matter
- If you don't know an answer, say: "That's a good question — may I get back to you with more detailed information?"
- Always end the call or email by thanking them warmly for their help.

Power Phrases

Here is a list of Power Phrases you should be weaving into your application package for support and services, and conversations with APD. They help frame your needs in language APD recognizes - making your message stronger, clearer, and more aligned with the criteria they use to determine eligibility and support.

- **Health and Safety Needs**

  Without daily in-home support, [Name] faces ongoing health and safety risks including missed medications, unsafe cooking, and potential injury from falls or wandering.

- **Activities of Daily Living (ADLs)**

  [Name] requires hands-on assistance with essential tasks like bathing, dressing, using the toilet, eating, transferring from bed to wheelchair, and maintaining basic hygiene."

- **Instrumental Activities of Daily Living (IADLs)**

  [Name] is unable to safely prepare meals, manage medications, clean their living space, or handle money without structured support.

- **Supervision Needs**

  Due to cognitive and behavioral challenges, [Name] requires continuous supervision to prevent self-harm, elopement, or accidental harm to others.

- **Behavioral Support**

  [Name] needs ongoing behavioral support to manage frequent outbursts and self-injurious behaviors that interfere with daily functioning and safety.

- **Vulnerable Adult**

  As a vulnerable adult with limited judgment and communication skills, [Name] is at risk of exploitation, abuse, or neglect without protective services.

- **Risk of Institutionalization**

  Without access to home- and community-based services, [Name] may be forced into an institutional setting due to the inability to remain safely at home.

- **Medically Necessary**

  The requested support is medically necessary to prevent further decline in [Name]'s physical and mental health, and to avoid unnecessary hospitalization.

- **Functional Limitations**

  [Name] has significant functional limitations in mobility, communication, and self-care that severely restrict independent living.

- **Community Integration**

  With proper support, [Name] can be meaningfully included in community life through adult day programs, volunteer work, and recreational activities.

- **Natural Supports Not Sufficient**

Although family provides extensive care, natural supports are not sufficient to meet [Name]'s needs for supervision, personal care, and community participation.

- **Support Needed for Employment/Volunteer Work**

  To maintain [Name]'s volunteer placement, services are needed for transportation, job coaching, and behavioral support in the workplace.

- **Person-Centered Plan**

  All requested services align with [Name]'s person-centered plan, which emphasizes independence, safety, meaningful daily activity, and dignity.

Appendix

APD Application for Services

APD Consent to Obtain or Release Confidential Information

agency for persons with disabilities
State of Florida

Application for Services

1. Applicant Information

Legal First Name: _____ **Legal Last Name:** _____

Legal Middle Initial: _____ **Suffix:** _____ **Date Of Birth:** _____ **Sex (circle one):** Male or Female

Social Security Number: _____ **-** ____ **-** _____ **Medicaid ID # (if known)**: _____

Race (for data purposes only): ☐White ☐ Black ☐ Asian ☐ Native American or Alaskan Native ☐ Other: _____

Mother's Maiden Last Name: _____**Mother's Maiden First Name:** _____

Select at least one Developmental Disability Diagnosis for eligibility consideration:

☐ Autism ☐ Cerebral Palsy ☐ Intellectual Disability ☐Prader-Willi Syndrome

☐ Spina Bifida ☐ Down Syndrome ☐ Phelan McDermid Syndrome

☐ Between the ages of 3 and 5 and at High Risk of Developing a Developmental Disability (If selecting this box, please explain):_____

(Please see Quick Guide: Applying for APD Services to utilize as a reference for proof of diagnosis documentation.)

Other Diagnosis (if applicable): _____

Applicant's Contact Information:

Address: _____

City: _____ **State:** _____ **Zip Code:** _____ **County:** _____

Phone #: _____

Email: _____

Preferred Method of Communication: _____ **Phone** or _____ **Email**

Preferred Language: _____

Applicant's Legal Representative: Please complete the information if the applicant has a legal representative. **(***For applicants under 18, this includes the parent, health care surrogate, or anyone designated by the parent(s) of the child to act on the parent(s)' behalf. For applicants 18 and over, this could include the applicant, anyone designated by the applicant through a Power of Attorney or Durable Power of Attorney, a medical proxy under Chapter 765, F.S., or anyone appointed by a Florida court as a guardian or guardian advocate under Chapter 393 or 744, F.S.)* Please proceed to Household Information section if applicant doesn't have a Legal Representative.

Legal Rep. First Name: _____ **Legal Rep. Last Name:** _____

Legal Rep. Middle Initial: _____ **Suffix:** _____

Type of Legal Representative: _____

Phone #: _____

Email: _____

Preferred Method of Communication: _____ **Phone** or _____ **Email**

2. Household Information: (Please complete this section if the applicant has a primary caregiver.)

Primary Caregiver's Legal First Name: _____ **Legal Last Name:** _____

Caregiver's Date of Birth: _____

Does the primary caregiver have health issues that prevent them from continuing to provide care? ☐ Yes or ☐ No

If Yes, please indicate the medical issues:

_____

Is the primary caregiver also providing primary care to a minor, elderly person, or another person with a disability?

☐ Yes or ☐ No

If Yes, please explain: _____

Are the current caregiver responsibilities preventing them from being employed? ☐ Yes or ☐ No

Does the applicant have a sibling with a developmental disability? ☐ Yes or ☐ No

3. Active Duty Military Service Member (if No to the first question, move to section 4.)

Is the applicant's parent or legal guardian an active-duty military service member? ☐ Yes or ☐ No

If Yes, please identify by name: _____

Was the family transferred to FL as part of military assignment? ☐ Yes or ☐ No

If Yes, did the applicant receive home and community-based waiver services in another state? ☐ Yes or ☐ No

4. Residency

Is the applicant a permanent resident of the State of Florida? ☐ Yes or ☐ No

If the applicant is a minor, is the parent or legal guardian domiciled in Florida? ☐ Yes or ☐ No

In many instances, APD can verify Florida residency or citizenship for applicants through information provided on this application form. If necessary, APD may request additional information or documentation to verify residency or citizenship in order to complete your application.

5. Eligibility Assessments

If necessary, do you agree to participate in clinical assessments that may be needed to determine eligibility for APD?

☐ Yes or ☐ No

6. I have received a copy of:

☐ HIPAA Notice of Privacy Practices

☐ Consent to Obtain or Release Protected Health Information

7. Voter Registration: YOU CAN APPLY TO REGISTER TO VOTE HERE (Form DS-DE-77):

See "National Voter Registration Act Preference Form/Application" (Department of State Form DS-DE 77), incorporated by reference in Rule 1S-2.048, *Florida Administrative Code*.

agency for persons with disabilities
State of Florida

Application for Services

8. CERTIFICATION AND SIGNATURE

By signing this application, I understand, acknowledge, and certify, under the penalties of perjury, the following:

- That all information provided is complete and accurate.
- That it is my responsibility to keep the Agency informed of any changes in address, email, or phone number and failure to do so may result in my application not being processed or case closure.
- That knowingly providing false representations constitutes an act of fraud. False, misleading, or incomplete information may result in the denial of my application.
- That additional information and/or documentation related to my application may be requested at any time.

Signature of Applicant: _____ **Date:** _____

Signature of Legal Representative (if applicable)**:** _____ **Date:** _____

Name of Person Assisting Applicant with Application (if applicable)**:**
Printed First & Last Name: _____
Relationship to Applicant: _____
Phone: _____
Signature of Person Assisting the Applicant: _____ **Date:** _____

Federal law requires the collection of your social security number as a condition of eligibility for Medicaid benefits under 42 U.S.C. 1320b-7 and the agency will collect, use, and release the number for administrative purpose as authorized under law.

AGENCY FOR PERSONS WITH DISABILITIES (APD)

CONSENT TO OBTAIN OR RELEASE PROTECTED HEALTH INFORMATION

YOUR LAST NAME	YOUR FIRST NAME	DATE OF BIRTH
STREET ADDRESS	STATE	ZIP
HOME TELEPHONE NUMBER	CELL PHONE NUMBER	EMAIL ADDRESS

[___] I hereby freely and voluntarily consent and authorize the Agency for Persons with Disabilities ("APD), or its agents or representatives, ***to obtain*** my protected health information from the person(s), agencies, institutions, or entities stated below for the purposes of treatment, payment, and health care operations.

[___] I hereby freely and voluntarily consent and authorize the Agency for Persons with Disabilities ("APD"), or its agents or representatives, ***to obtain only specific portions*** of my protected health information from the person(s), agencies, institutions, or entities stated below for the purposes of treatment, payment, and health care operations.

[___] I hereby freely and voluntarily authorize the Agency for Persons with Disabilities ("APD"), or its agents or representatives, ***to discuss, access, use, and/or disclose matters*** related to my protected health information to or from the person(s), agencies, institutions, or entities stated below for the purposes of treatment, payment, and health care operations.

The information requested below will be accessed, used, or disclosed for the following purposes:

[___]	Medical Reports	[___]	Social Service Reports
[___]	Academic Records and Plans	[___]	Speech and Hearing Reports
[___]	Habilitation Plans / Support Plans	[___]	Physical Therapy Reports
[___]	Psychological Reports	[___]	Occupational Therapy Reports
[___]	Other (Please specify)		

Name, address, telephone number, email address, and/or fax number of person, agency, institution, or entity from whom my protected health information is to be obtained:

Name, address, telephone number, email address, and/or fax number of person, agency, institution, or entity to whom my protected health information may be discussed and/or disclosed:

- I understand that my protected health information may be accessed, discussed, used, and/or disclosed for purposes of treatment, payment, healthcare operations, and as otherwise permitted or required by law.
- I also understand that information disclosed under this Consent to Obtain or Release Protected Health Information might be re-disclosed by the recipient and it may no longer protect my health information under federal or state law, if the recipient of the information is obligated to comply with the requirements of HIPAA.
- I understand that I may revoke this Consent by writing to APD, except to the extent that action has already been taken based on this Consent to Obtain or Release Protected Health Information.
- I know that I may inspect or copy any information used / disclosed under this consent.

This consent expires on _____. I understand that if this consent has not been revoked by me or it does not specify a consent expiration date, it will automatically expire ninety (90) calendar days from the date of signing the consent.

By your signature below, you acknowledge that you understand and agree to the above information.

Signature of Client		Date	

If you are a client's legal representative, you must state your title and provide documentation proving your legal authority to act on behalf of the client.

Signature of Legal Representative		Date	Relationship of Legal Representative