

Aging and Disability Services Division

Developmental Services

Application for Developmental Services

<input type="checkbox"/> DESERT REGIONAL CENTER 7150 Pollock Drive Las Vegas, NV 89119 Phone: 702-486-7850 Fax: 702-486-5855	<input type="checkbox"/> RURAL REGIONAL CENTER 1550 E. College Parkway Carson City, NV 89706 Phone: 775-687-5162 Fax: 775-688-1001	<input type="checkbox"/> SIERRA REGIONAL CENTER 10375 Professional Circle Reno, NV 89521 Phone: 775-687-2600 Fax: 775-688-1947
Applicant Information		
Applicant's Name (First, Last):		Preferred Name:
Date of Birth (MM/DD/YY):		Application Date:
Race/Ethnicity:		
<input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Bi-racial/multi-racial	<input type="checkbox"/> Black/African American <input type="checkbox"/> Caucasian/White <input type="checkbox"/> Filipino <input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> Middle Eastern/North African <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> I choose not to answer <input type="checkbox"/> Unknown
Social Security Number:		
Nevada Resident: <input type="checkbox"/> Yes <input type="checkbox"/> No		US Citizen or Legal Resident: <input type="checkbox"/> Yes <input type="checkbox"/> No
Home Address: (Street, City, State, Zip Code)		
Mailing Address: (Street, City, State, Zip Code)		
Email Address:		
Phone Number:	Mobile Phone Number:	Alternate Phone Number:
Primary Language of Applicant:		
Interpreter/Communication Aids Needed? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Select Disability:	<input type="checkbox"/> Developmental Delay (if under age 6)	<input type="checkbox"/> Intellectual Disability
	<input type="checkbox"/> Developmental Disability If selecting this box, specify:	<input type="checkbox"/> Autism Spectrum Disorder <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Fetal Alcohol Spectrum Disorder <input type="checkbox"/> Seizure Disorder <input type="checkbox"/> Traumatic Brain Injury
	<input type="checkbox"/> Other (specify):	
Received Special Education: <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, provide Name of School:
School Address:		

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Applicant Name (First, Last):		
Other services or programs provided (Applied Behavior Analysis, Nevada Early Intervention Services, Therapies, Physicians, Psychologist, Regional Centers, etc.):		
This information is used to comply with state law NRS 239B.022- 239B.026 . Only the Department of Health and Human Services will have access to this information. Providing this information is optional.		
Sex Assigned at Birth: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Prefer not to disclose	Gender Identity: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Genderqueer/gender non-conforming <input type="checkbox"/> Transgender Male <input type="checkbox"/> Transgender Female <input type="checkbox"/> Not listed (specify) <input type="checkbox"/> Prefer not to disclose	Sexual Orientation: <input type="checkbox"/> Heterosexual <input type="checkbox"/> Homosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Not listed (specify): <input type="checkbox"/> Prefer not to disclose
SSDI Benefits: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending	Nevada Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending	
SSI Benefits: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending	Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending	
Medicaid ID Number:	Medicare ID Number:	
<input type="checkbox"/> Private/Other Insurance	Insurance Name:	Insurance ID: (if available)
Referred By:		
<input type="checkbox"/> Bureau of Vocational Rehabilitation <input type="checkbox"/> Division of Child and Family Services (DCFS) <input type="checkbox"/> Family/Self	<input type="checkbox"/> Katie Beckett Program <input type="checkbox"/> Nevada Early Intervention Services (NEIS) <input type="checkbox"/> Out of State	<input type="checkbox"/> School District <input type="checkbox"/> Social Services (Adult) <input type="checkbox"/> Social Services (Child) <input type="checkbox"/> Other (specify)
Parent or Guardian Information		
Guardianship status: <input type="checkbox"/> Minor Legal guardianship <input type="checkbox"/> Public guardianship <input type="checkbox"/> None listed/no guardianship in place		
Parent/Legal Guardian Name:		
Parent/Legal Guardian Address: (Street, City, State, Zip Code)		
Email Address:		
Phone Number:	Mobile Phone Number:	Alternate Phone Number:
Parent/Legal Guardian Primary Language:		

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Consent	
<p>I am requesting services from Developmental Services. Developmental Services is a state approved program that helps people in Nevada with intellectual or developmental disabilities. I understand that I can cancel this request at any time. I also understand that all the information Developmental Services collects will be kept private. By signing this form, I agree to any psychological tests or evaluations needed to see if I am eligible. Developmental Services will deny my application if they lose contact with me, don't get the information needed, or if I am not eligible for Developmental Services.</p>	
Applicant Signature	Date
Parent/Legal Guardian Signature	Date