

How did you learn about Partners in Policymaking? (other than this application)

Please complete all of the following to the best of your ability. Incomplete applications will not be reviewed. It is alright for someone to assist you in completing this application.

Date: _____ County: _____

Name: _____

Address: _____

City: _____, NJ Zip Code: _____

Telephone: _____ Date of Birth: _____

E-Mail: _____ Sex: M F

1. Are you a PERSON WITH A DEVELOPMENTAL DISABILITY?

[see definition]

YES NO

2. Are you the FAMILY MEMBER of a person with a developmental disability?

YES NO

(If more than one person with DD in your family, please list each individual by relationship - son, spouse, sister, etc.)

Person 1: _____

Person 2: _____

Person 3: _____

Person 4: _____

What is a Developmental Disability?

The term 'developmental disability' means a severe, chronic disability of an individual that—
(i) is attributable to a mental or physical impairment or combination of mental and physical impairments;
(ii) is manifested before the individual attains age 22;
(iii) is likely to continue indefinitely;
(iv) results in substantial functional limitations in 3 or more of the following areas of major life activity:
(I) Self-care.
(II) Receptive and expressive language.
(III) Learning.
(IV) Mobility.
(V) Self-direction.
(VI) Capacity for independent living.
(VII) Economic self-sufficiency; and
(v) reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated.

3. If Yes:

a. Describe how the disability affects the ability to participate in at least three (3) areas of major life activity for each individual in your family:

Person	Age	Areas of Function Affected
1	_____	_____
2	_____	_____
3	_____	_____
4	_____	_____

[add on separate paper if required]

b. What is the disability (impairment) for each person listed?

1. _____
2. _____
3. _____
4. _____

4. Why are you interested in participating in the Partners in Policymaking program?

[add on separate paper if needed]

5. What skills or new information do you wish to get from this program:

6. Do you understand that you must commit to attend eight (8) two-day sessions, held monthly from April through November?

YES NO

7. Are you willing and able to do homework as assigned (primarily reading)?

YES NO

8. Are you able to travel independently to attend the regularly scheduled meetings?
YES NO

9. Are any special accommodations needed for you to participate in this program?
YES NO

a. If yes, describe accommodations needed (accessibility, readers, respite care, personal assistance services, etc.)

b. Do you use prescribed medications?

YES NO

- If Yes, are you able to self-administer medications?

YES NO

10. Have you ever stayed overnight at a hotel, either by yourself or with a roommate?
YES NO

11. Please tell us about any experience you (or any of the individuals listed) have in advocating for people with developmental disabilities? [add on separate paper if needed]

12. Please tell us a little about yourself and your family:

13. Please list two references – name, address, phone number and E-mail:

a. _____

b. _____

14. Did someone assist you in completing this application? YES NO

Please mail, Fax or E-mail completed Application
ATTENTION: Dennie Todd, NJCDD, PO Box 700, Trenton, NJ 08625-0700
or E-mail to: dennie.todd@njddc.org



Partners in Policymaking

Application for Participation



The New Jersey Council on Developmental Disabilities
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