PARTNERS IN POLICYMAKING®
Advocacy Training Program

Application for Participation

Partners in Policymaking® participants and graduates are people with developmental disabilities\* or parents of young children with developmental disabilities with a desire to improve and expand the system of supports that enable persons with developmental disabilities to be fully included in their communities. Program participants attend and participate in six two-day advocacy training and skill building workshops. These sessions run between January and June. Completion of this application and selection for the Partners in Policymaking® program requires a substantial commitment of time, motivation, and energy.

If accepted, I, Click here to enter text. agree to the conditions for participation in Partners in Policymaking® and understand that it is an initiative of the Louisiana Developmental Disabilities Council (Council). Under this agreement, a comprehensive leadership training program will enable participants to maximize their abilities to advocate for appropriate supports and services designed to increase the self-determination, independence, productivity, and full inclusion of people with developmental disabilities in all facets of community life in Louisiana.

The Louisiana Partners in Policymaking® (PIP) application form is attached. Before answering any questions, please read ALL instructions, questions, AND the eligibility definitions.

Applicants must complete ALL sections of the PIP application and submit it to **the Council office no later than September 30th** to be considered for next year’s class.

Applications may be submitted by e-mail, fax, U.S. Mail, or by direct delivery.

If you have any questions or need assistance or accommodations to complete this PIP application form, please contact the Louisiana Developmental Disabilities Council as indicated on the last page of this application form.

**\*Applicants or their child must have a developmental disability according to the definition included in the Developmental Disabilities Assistance and Bill of Rights Act of 2000, PL106-402.**

Please review the federal **definition of Developmental Disabilities** below and **initial** the statement at the bottom of this page.

(A) IN GENERAL- 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:

1. Self-care.
2. Receptive and expressive language.
3. Learning
4. Mobility
5. Self-direction
6. Capacity for independent living
7. 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.

(B) INFANTS AND YOUNG CHILDREN-An individual from birth to age 9, inclusive, who has a substantial developmental delay or specific congenital or acquired condition, may be considered to have a developmental disability without meeting 3 or more of the criteria described in clauses (i) through (v) of subparagraph (A) if the individual, without services and supports, has a high probability of meeting those criteria later in life.

Initial the following:

Please initial. I certify that I have read the definition of developmental disabilities and understand that this must apply to me and/or my child in order to be considered for the Partners in Policymaking program.

**Background Information**

Name Click here to enter text. Click here to enter text . Enter text.

 LAST FIRST MIDDLE INITIAL

Address Click here to enter text Apt. No to enter text.

City Click here to enter text. , LA ZIP Click here to enter text.

Home Phone Click here to enter text. Cell Phone Click here to enter text.

Email Click here to enter text .

1. Gender? MALE [ ]  FEMALE [ ]
2. Ethnic background [optional]: [ ] African American [ ] Caucasian

 [ ] Hispanic [ ] Asian–Pacific Islander [ ] American Indian

 [ ]  Other Click here to enter text.

1. Have you applied for a previous Partners’ class? [ ] YES [ ]  NO If yes, year(s): Click here to enter text.
2. Are you a **PERSON** with a developmental disability? [ ] YES [ ]  NO
3. Age Click here to enter text.
4. Disability/Diagnosis Click here to enter text.
5. Your age at onset of disability? (Birth, age) text.

 (If you answered YES to question 4, skip to question 6)

5. Are you a **PARENT** of a **YOUNG** **CHILD** with a developmental disability?

 [ ] YES [ ]  NO

**COMPLETE ONLY FOR YOUR CHILD WITH A DEVELOPMENTAL DISABILITY:**
[If there is more than one child with a developmental disability please provide this information for each child on a separate sheet.]

1. Child’s Name Click here to enter text.
2. Child’s Age Click here to enter text.
3. Disability/Diagnosis Click here to enter text.
4. Child’s Gender [ ]  MALE [ ]  FEMALE
5. Child’s age at onset of disability Click here to enter ext.
6. Does your child live at home with you?

 [ ]  YES [ ]  NO

 If not, where? Click here to enter text.

g. Check how the disability affects you or your child.
[ ]  Physical [ ]  Cognitive

[ ]  Sensory [ ]  Emotional/ Behavioral

[ ]  Other Click here to enter text.

1. **Are you or your son/daughter receiving or waiting for services by the Regional Human Services District or Authority, Office for Citizens with Developmental Disabilities, or Office of Behavioral Health?** [ ] YES[ ] NO
2. If Yes, check all that apply that you or your child is receiving: (receiving the service or on a waiting list to receive the service):

 [ ]  New Opportunities Waiver [ ]  Supports Waiver

 [ ]  Children’s Choice [ ]  Individual/Family Support

 [ ]  Flexible Family Fund [ ]  EarlySteps

 [ ]  EPSDT

 [ ]  Other: Click here to enter text.

1. If No, why **have you or your son/daughter been determined ineligible for these services?** [ ]  YES [ ]  NO

Click here to enter text.

1. If you or your child has not applied for eligibility for any of these services, please explain why.

Click here to enter text.

1. How does your disability or your child’s disability affect your daily life, his/her daily life or the daily life of your family?

Click here to enter text.

**PIP Participation Requirements and Required Signature**

If accepted into the Partners in Policymaking® program, I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, agree to:

1. Participate in **ALL** six (6) two-day weekend Partners in Policymaking® training sessions, including completion of all activities, tasks, classroom assignments and/or homework assignments prior to graduation in June;
2. Arrive on time to each Friday session, return from breaks on time and stay at the hotel until the weekend sessions are over as follows:

Friday, Day One – 12:00 pm - 9:00 pm and

Saturday, Day Two – 8:30 am - 3:00 pm;

1. **NOT** invite spouses, other family members, guests, or others to attend the weekend training sessions (beginning Friday afternoon and concluding late Saturday afternoon), with the exception of the graduation ceremonies;
2. Complete and submit course evaluation forms prior to leaving each session;
3. Show competencies through actions during and between sessions, such as letter writing, phone calls, participation at local/state meetings, presenting testimony, and writing news articles;
4. Maintain and submit records of these actions and records of contacts that relate to or result from the participation in Partners in Policymaking®, such as news media, public officials, action alerts, service organizations and/or community programs, phone calls, public presentations/speeches, meetings attended, organizations joined;
5. Avoid consuming, or being under the influence of, alcohol or other non-prescribed narcotics immediately preceding and during session hours of 12:00 pm – 9:00 pm on Fridays and 8:30 am – 3:00 pm on Saturdays (this includes breaks); and
6. Submit completed reimbursement form within 7 days of each weekend training session.

**Initial** to show your understanding of the **Policy on Absences** below. Initial

An excused absence may be granted for emergencies based on the specifics of each circumstance. Qualifying emergencies are those which satisfy both conditions below.

1. A circumstance or combination of circumstances that is unforeseen and occurs on or prior to the morning of the Friday of the session that will be missed or that occurs during the weekend making early departure necessary and
2. A situation calling for immediate or continued action by the participant with no other natural support available.

Approved absences due to qualifying emergencies will be governed by the following.

1. An approved absence or tardiness due to a qualifying emergency will result in makeup work assignments
2. Failure to complete makeup work assignments within the time provided will result in dismissal from the program.

**Initial** to show your understanding of, and agreement with, the following:

Initial I certify that all of the information provided in this application has been voluntarily disclosed and is complete and accurate to the best of my knowledge.

Initial I give the Louisiana Developmental Disabilities Council permission to share the answers to the questions on this application with PIP staff, PIP applicant interview panels, and the PIP selection committee.

Initial. If selected, I permit the Louisiana Developmental Disabilities Council and/or any of its relevant initiatives to use photographs, videos, and/or statements of me and/or my family member(s) in Louisiana Developmental Disabilities Council publications and publicity material.

Initial. If selected, I understand that **my failure to comply with any of the requirements listed may result in my release from the program**.

Initial. If selected, I will make a firm commitment to participate in **ALL** six mandatory two-day weekend sessions in Baton Rouge and complete **ALL** assignments.

Initial. If selected, I understand that I will automatically become a member of LaCAN

Initial. If selected, I understand that I will be automatically enrolled to receive LaDDC News articles.

**Signature:** Click here to enter text. **Date:** Click here to enter text.

**Print Name:** Click here to enter text.

All selected participants can expect the Council, through the PIP program, to provide:

* 1. Face-to-face best practices and state-of-the-art information available from national and state experts in the field of developmental disabilities;
	2. Reading materials, suggestions and resources to familiarize participants with a wide range of topics related to developmental disabilities and with information specific to identified areas of interest;
	3. Role play and direct experiences to assist participants in their abilities to influence public policy at the local, state and federal levels;
	4. Reimbursement of approved travel costs to and from weekend training sessions (mileage is reimbursed at the rate of $0.26/mile);
	5. Lodging on a **double occupancy basis**;
	6. Reimbursement up to $100/ weekend for non-covered respite services, personal assistant services, and facilitator services **(this does not apply if you receive services through a waiver or residential setting)**;and
	7. All reimbursement within 30 days of receipt

**PIP Applicant Information**

(Please use extra pages if necessary.)

1. Please tell us a little about yourself and your family, including information on other natural supports who would provide care to your son/daughter while you are at Partners’ sessions.

Click here to enter text.

1. Please share your views on community inclusion and integration.

Click here to enter text.

1. What is something you would like to see change in the current service delivery system? Please be specific and give details.

Click here to enter text.

1. Please list any activity, membership, and/or office held in advocacy organizations. (This is not a requirement for participation)

Click here to enter text.

1. Why do you want to participate in Partners in Policymaking®?

Click here to enter text.

1. Identify one or two specific disability related problems that are of particular interest to you and what are your ideas to address this issue?

Click here to enter text.

1. Tell us something that you have done which shows you can complete a long term project and share information.

Click here to enter text.

1. What do you hope to gain from Partners in Policymaking®?

Click here to enter text.

1. Do you know any Partners in Policymaking graduates? [ ]  YES [ ]  NO

 If yes, please list who? Click here to enter text.

1. How did you learn about Partners in Policymaking®?

[ ]  FHF Center [ ]  Newspaper [ ]  Partners graduate

[ ]  EarlySteps [ ]  OCDD office [ ]  Advocacy Group

[ ]  Facebook [ ]  LaCAN [ ]  DD Council

[ ]  Individual Click here to enter text.

[ ]  Other Click here to enter text.

1. Please list 2 references and their appropriate information below.

Reference’s Name Click here to enter text.

Phone Number Click here to enter text.

Email Address Click here to enter text.

Reference’s Name Click here to enter text.

Phone Number Click here to enter text.

Email Address Click here to enter text.

1. If anyone helped you prepare this application, please provide his or her name, address and phone numbers:

Name Click here to enter text.

Address Click here to enter text.

City Click here to enter text. State Click to enter text. Zip Click here to enter text. Home Phone Click here to enter text. Cell Phone Click here to enter text.

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The following two questions are not part of the selection process and will not be considered by the selection committee. However, if selected, this information allows appropriate planning for any accommodations to ensure all participants are successful in PIP.

Are there any special disability accommodations necessary for you to participate in this program? If yes, please describe them (accessibility, interpreters, respite and assistance to understand written materials, personal care attendant, or other accommodations). [ ]  YES [ ]  NO

Do you have any special dietary needs? If yes, please describe them.

 [ ]  YES [ ]  NO

If yes, please describe your needs. Click here to enter text.

**APPLICATION CHECKLIST AND SUBMISSION INSTRUCTIONS**

**Did you remember to do these things?**

[ ] Complete **ALL** sections of the application? Applications with incomplete sections and/or background information will **NOT** be considered.

[ ]  Please be sure to include the names and contact information on 2 references.

[ ] Include any additional pages.

On or before the deadline of **September 30th**, please mail, fax or e-mail all pages of this application and any attachments to:

Louisiana Developmental Disabilities Council

Attn: Partners in Policymaking®

P.O. Box 3455

Baton Rouge, LA 70821 – 3455

Phone: 225-342-6804

Toll Free: 1-800-450-8108

Fax: 225-342-1970

[www.laddc.org](http://www.laddc.org)

For questions or information, please contact:

Rodney Anthony, Program Monitor

225-342-6804

rodney.anthony@la.gov

or

Liz Gary, Partner’s in Policymaking Coordinator

504-858-8633

partners\_coordinator@charter.net