PARTNERS IN POLICYMAKING®
Advocacy Training Program

Application for Participation

Partners in Policymaking® is an initiative of the Louisiana Developmental Disabilities Council (Council). Partners is a comprehensive leadership training program that 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.

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.

**Class Schedule**

Session 1: January 12 -14, 2023

Session 2: February 10 - 11, 2023

Session 3: March 3 – 4, 2023

Session 4: March 31 – April 1, 2023

Session 5: May 5 – 6, 2023

Session 6: June 2 - 3 , 2023

Weekend sessions begin with check-in at 12:00 p.m. on the first day and end at 3:00 p.m. on the second day (**with the exception of Session 1 which begins at 3:00 p.m. on the first day**). Lodging and meals will be provided. Sessions are held at Baton Rouge Marriott, 5500 Hilton Avenue, Baton Rouge, LA 70808.

Attendance is required at each weekend session. Will you make a time commitment of two days (**three days in January**), one weekend a month (January through June), for six months? [ ] YES[ ] NO

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 through the online application or by e-mail, fax, or U.S. Mail.

**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.

**PIP Application**

(Please use extra pages if necessary.)

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.

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.

1. 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:

 [ ]  New Opportunities Waiver [ ]  Supports Waiver

 [ ]  Children’s Choice [ ]  Residential Options Waiver

 [ ]  Individual/Family Support [ ]  Flexible Family Fund

 [ ]  EPSDT [ ]  EarlySteps

 [ ]  Other: Click here to enter text.

1. If No, why **have you or your son/daughter not been determined eligible for these services?**

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. Is your son/daughter receiving special education services?

[ ] YES[ ] NO

If yes, please describe.

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.

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 people with disabilities being fully included in their communities.

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® and what do you hope to gain?

Click here to enter text.

1. Identify one or two specific disability related problems that are of particular interest to you. If you have any ideas to address these issues, please share.

Click here to enter text.

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

[ ]  FHF Center [ ]  Newspaper [ ]  Advocacy Group

[ ]  EarlySteps [ ]  OCDD office [ ]  DD Council

[ ]  Facebook [ ]  LaCAN

[ ]  Partners graduate(s) Click here to enter text.

[ ]  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.

**APPLICATION CHECKLIST AND SUBMISSION INSTRUCTIONS**

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

[ ] Complete **ALL** sections of the application?

[ ] Include any additional pages, if necessary.

On or before the deadline of **September 30, 2022** please submit online or 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 14148

Baton Rouge, LA 70898

Phone: 225-342-6804

Toll Free: 1-800-450-8108

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

For questions or information, please contact:

Ebony Haven, LaDDC Deputy Director

225-342-6804

ebony.haven@la.gov