



South Carolina Partners in Policymaking® is an innovative evidence-based leadership training program created to teach adults with disabilities and parents of young children with disabilities to

- Become agents of long-term change.
- Be active partners with policymakers whose decisions affect their future.
- Dream about a future with possibilities.
- Become empowered, strengthened, and encouraged to advocate within their communities.

Over 400 people in South Carolina—and thousands more around the world—have graduated from Partners in Policymaking® classes since the course’s development by the Minnesota Developmental Disabilities Council in 1987. There have been 23 Partners in Policymaking® classes in South Carolina since 1999. Alumni have gone on to contribute to non-profit boards, planning committees, and government councils. Some have given legislative testimony, and many hold a variety of leadership positions across the state.

We invite you to duplicate and share this application. Alternative format requests and accommodations to complete this application should be directed to William Farrior, Program Assistant, SC DD Council: 803-734-4190, william.farrior@admin.sc.gov .

Application Checklist

Complete all sections of the application. If needed, **we can assist you in completing your application.**

Review the definition of developmental disability provided. DD Council can **only** accept participants who meet the DD Act criteria for developmental disability.

Provide complete and current contact information for two references.

Prepare for a brief telephone interview to be completed after your application has been reviewed.

Applications will be accepted all year. If classes are full your application will remain effective for the following class

Submitting your Application

- Email**
- You may submit a scanned handwritten application or complete a typed word document application. You may attach additional handwritten sheets or type as much as you need.
 - If filling in a digital document, use the click text boxes to enter information and *save your work often*.
 - Application must include a signature to certify information provided is true and provided voluntarily. You may upload an electronic signature using the control box *or* type your name in the signature box.
 - Attach your application to an email and send to william.farrior@admin.sc.gov .

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- Mail**
- You may submit a handwritten or typed application.
 - You may attach additional sheets to your application.
 - Sign your application.
 - Mail to
SC DD Council
Edgar A. Brown Building
1205 Pendleton St., Suite 372
Columbia, SC 29201

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- Fax**
- You may submit a handwritten or typed application.
 - You may attach additional sheets to your application.
 - Sign your application.
 - Fax to (803)734-0241

Application

First Name			Last Name		
Address					
County			City		
Email			Second Email		
Phone			Second Phone		
Date of Birth			Ethnicity		
Gender			Preferred Pronouns		

Developmental Disability

Developmental disability is defined by the Developmental Disabilities Bill of Rights and Assistance Act of 2000. Partners in Policymaking® invites adults with developmental disability and parents of children with a developmental disability.

- A.** 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.
- 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 paragraph A. if the individual, without services and supports, has a high probability of meeting those criteria later in life.

Are you an adult with a developmental disability?

Yes No

Are you the parent of a child with a developmental disability?

Yes No

Please describe the disability and how it affects daily life.

Developmental Disability Act Criteria

Please select the type of disability below

- | | | |
|--|--|---|
| <input type="checkbox"/> Autism (ASD/PDD) | <input type="checkbox"/> Down Syndrome | <input type="checkbox"/> Developmental Delay |
| <input type="checkbox"/> Cerebral Palsy (CP) | <input type="checkbox"/> Spina Bifida | <input type="checkbox"/> Intellectual Disability (ID) |
| <input type="checkbox"/> Fetal Alcohol Syndrome | <input type="checkbox"/> Tourette Syndrome | <input type="checkbox"/> Fragile X Syndrome |
| <input type="checkbox"/> Attention Deficit/Hyperactive Disorder (ADD/ADHD) | <input type="checkbox"/> Central Auditory Processing Disorder (CAPD) | <input type="checkbox"/> Velocardiofacial Syndrome |
| <input type="checkbox"/> Neural Tube Defect | <input type="checkbox"/> Angelman Syndrome | <input type="checkbox"/> Other: _____ |

If you are applying as a parent of a child with a disability, how old is your child? _____

Additional DD Act Criteria

Please select:

- | | Yes | No |
|---|--------------------------|--------------------------|
| Manifested before age 22: | <input type="checkbox"/> | <input type="checkbox"/> |
| Likely to continue indefinitely: | <input type="checkbox"/> | <input type="checkbox"/> |

Results in substantial functional limitations in three (3) or more of the following: (please select)

- | | | |
|--|--|---|
| <input type="checkbox"/> Self-care | <input type="checkbox"/> Receptive and expressive language | <input type="checkbox"/> Learning |
| <input type="checkbox"/> Mobility | <input type="checkbox"/> Capacity for independent living | <input type="checkbox"/> Self-determination |
| <input type="checkbox"/> Economic Self-sufficiency | | |

Do you receive long-term individualized services and supports?

Yes No

Please explain: _____

About You

Please tell us a little about yourself and your family.

Why are you interested in participating in Partners in Policymaking®?

What disability issues are you interested in impacting?

What services do you or your child or your family receive?

Advocacy

What does “advocacy” mean to you?

Tell us about a time when you have advocated.

List advocacy organizations you have been a part of and any offices held.

Write about a time you worked with other people to reach a goal or complete a project.

References

Please provide the names and contact information of two people Partners in Policymaking® staff can talk with about your experiences.

First Name

Last Name

Phone No.

Email

First Name

Last Name

Phone No.

Email

Accommodation Request

Do you require accommodations such as ASL interpreter, assistive technology, large print materials, etc., to participate? Yes No

Please list:

Schedule

Partners in Policymaking® classes are held once a month on Friday and Saturday for five months in Columbia, SC. Details on the venue will be provided with your acceptance package. Classes begin at 12:00 PM on Friday and end by 4:00 PM on Saturday.

Dates will be confirmed upon acceptance.

Lodging is provided to participants travelling more than **50 miles** to class location.

Participation Requirements

Partners in Policymaking® requires a substantial commitment of time, motivation, and energy. Participants are expected to attend **all sessions**, be active participants, and contribute to a group policy project.

If accepted into SC Partners in Policymaking®, I agree to:

- **Travel to Columbia to attend regularly scheduled training sessions.**
- **Commit to attend all two-day training sessions.**
- **Participate in a group policy project**

I give permission to the SC DD Council to share the answers to the questions on this application with staff.

By entering my name below, I certify that I am the applicant represented by the information on this application, as well as guarantee that all of the information provided is accurate to the best of my knowledge and has been voluntarily disclosed. For the purpose of submission of this application, the insertion of your name below qualifies as an electronic signature.

Signature: _____

Date: _____

Please click the box above to insert digital signature, or type your name in the signature field.