

Lilia Teninty  
**Authorized signature**

**Number:** APD-AR-17-003  
**Issue date:** 1/20/2017

**Topic:** Developmental Disabilities

**Due date:**

**Subject:** New Form 539D

**Applies to (check all that apply):**

- |  |   |
|--|---|
| <input type="checkbox"/> All DHS employees                               | <input type="checkbox"/> County Mental Health Directors                                 |
| <input type="checkbox"/> Area Agencies on Aging                          | <input type="checkbox"/> Health Services  |
| <input type="checkbox"/> Aging and People with Disabilities              | <input checked="" type="checkbox"/> Office of Developmental Disabilities Services(ODDS) |
| <input type="checkbox"/> Self Sufficiency Programs                       | <input checked="" type="checkbox"/> ODDS Children’s Intensive In Home Services          |
| <input checked="" type="checkbox"/> County DD Program Managers           | <input type="checkbox"/> Stabilization and Crisis Unit (SACU)                           |
| <input checked="" type="checkbox"/> ODDS Children’s Residential Services | <input type="checkbox"/> Other ( <i>please specify</i> ):                               |
| <input type="checkbox"/> Child Welfare Programs                          |   |

**Action required:** Use this revised version of [form 539D](#) for the OSIPM process through CMEU.

**Reason for action:** The revised form contains the updated information needed for the application process

**Field/stakeholder review:**  Yes  No

**If yes, reviewed by:**

*If you have any questions about this action request, contact:*

<b>Contact(s):</b>	Barbara Carroll-- 503-378-5795 May Martin—503-947-2318		
		<b>Fax:</b>	
<b>Email:</b>	<a href="mailto:Barbara.e.carroll@dhsoha.state.or.us">Barbara.e.carroll@dhsoha.state.or.us</a> <a href="mailto:May.martin@dhsoha.state.or.us">May.martin@dhsoha.state.or.us</a>		