

Maryland Department of Health and Mental Hygiene
DEVELOPMENTAL DISABILITIES ADMINISTRATION
APPLICATION FOR ELIGIBILITY

To determine eligibility for the Developmental Disabilities Administration (DDA) services, whether state or medicaid funded, you must complete this form. Low Intensity Support Services (LISS) do not require an application.

*If you need help with this application, call Toll Free 1-877-4MD-DHMH * TTY for Disabled - Maryland Relay service 1-800-735-2258*

PART I: APPLICANT'S INFORMATION

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LAST Name

FIRST Name

MIDDLE Name

Date of Birth (MM/DD/YYYY): **Social Security Number:**

Permanent Mailing Address:

<i>Street Address</i>		<i>Apt#</i>	
<i>City</i>	<i>State</i>	<i>Zip Code</i>	<i>County of Residence</i>

Are you a resident of Maryland? Yes No

Telephone: _____ **Email:** _____

Day	
Cell	
Evening/Other	

Have you ever applied for Medical Assistance in Maryland? Yes No

If yes, when? _____

If eligible, please provide your Medical Assistance Number: _____

Start Date: _____ **End Date:** _____

Please list your Managed Care Organization (MCO) if you have one: _____

and your primary care physician: _____

** You must apply for Medical Assistance before you can receive funding for services from the DDA.*

Supportive documentation attached to this application as available: Yes No

Medicaid Card Social Security Card

FOR REGIONAL OFFICE USE ONLY

Regional Office: _____ **Date Received:** _____

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PART II: APPLICANT SELF ASSESSMENT

Please check all disabilities that you have been diagnosed with:

- | | | |
|--|---|--|
| <input type="checkbox"/> Autism | <input type="checkbox"/> Deafness/Severe hearing impairment | <input type="checkbox"/> Speech/Language impairment |
| <input type="checkbox"/> Behavioral problems | <input type="checkbox"/> Epilepsy/Seizure disorder | <input type="checkbox"/> Spina bifida |
| <input type="checkbox"/> Blindness/Severe visual impairment | <input type="checkbox"/> Head injury | <input type="checkbox"/> Spinal cord injury |
| <input type="checkbox"/> Cerebral palsy | <input type="checkbox"/> Intellectual Disability | <input type="checkbox"/> other neurological impairment |
| <input type="checkbox"/> Chemical dependency (Includes alcoholism) | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Mental illness |
| <input type="checkbox"/> Cystic fibrosis | <input type="checkbox"/> Orthopedic impairment | |

Other:

Please attach copies of the following reports if appropriate, to support your disability, and note their attachment by checking them off below:

- | | |
|---|---|
| <input type="checkbox"/> Medical Records | <input type="checkbox"/> Neuropsychological Evaluations |
| <input type="checkbox"/> Psychological Evaluations | <input type="checkbox"/> Special Education Records |
| <input type="checkbox"/> Other professional assessments | <input type="checkbox"/> Vocational Evaluations |

Please Identify: _____

YOUR APPLICATION CANNOT BE PROCESSED WITHOUT YOUR EVALUATIONS/RECORDS

Please check any statement that tells us about you and the supports you usually need:

HOW DO YOU GET AROUND?	DO YOU REQUIRE ASSISTANCE?
<input type="checkbox"/> I walk independently.	<input type="checkbox"/> I do not need assistance.
<input type="checkbox"/> I can walk unaided, but with difficulty.	<input type="checkbox"/> I need occasional assistance. Several hours per day up to 3 days per week.
<input type="checkbox"/> I require supportive devices when I walk.	<input type="checkbox"/> I need minimal daily assistance. 1-2 hours per day.
<input type="checkbox"/> I use a power wheelchair.	<input type="checkbox"/> I need substantial daily assistance. 8 hours or more per day.
<input type="checkbox"/> I use a manual wheelchair.	<input type="checkbox"/> I need continuous assistance when I am awake.
<input type="checkbox"/> I use a scooter.	<input type="checkbox"/> I need continuous 24 hours per day assistance.
<input type="checkbox"/> I am unable to move independently.	<input type="checkbox"/> Other.
<input type="checkbox"/> Other.	

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Please check any statement that tells us about you and the supports you usually need:

HOW DO YOU COMMUNICATE?	DO YOU USE ANY OF THESE SERVICES?
<input type="checkbox"/> I speak clearly and can be understood.	<input type="checkbox"/> Speech Therapy
<input type="checkbox"/> My speech is difficult to understand.	<input type="checkbox"/> Occupational Therapy
<input type="checkbox"/> I use gestures to communicate.	<input type="checkbox"/> Physical Therapy
<input type="checkbox"/> I use sign language to communicate.	<input type="checkbox"/> Specialized Medical Care
<input type="checkbox"/> I require a communication device to communicate.	<input type="checkbox"/> Behavioral Support Service
<input type="checkbox"/> I need help from others to communicate.	<input type="checkbox"/> Counseling
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Psychiatric Treatment
	<input type="checkbox"/> Other: _____

Please check any statement that tells us about you and the supports you usually need:

<u>PERSONAL SKILLS</u>	<u>COMPLETELY INDEPENDENT</u>	<u>NEEDS ASSISTANCE</u>	<u>COMPLETELY DEPENDENT</u>
EATING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DRESSING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
BATHING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TOILETING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GROOMING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TRANSFERS IN/OUT OF BED	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PREPARES SIMPLE FOOD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
COMPLETES HOUSEHOLD TASKS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
USES PUBLIC TRANSPORTATION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
USES THE TELEPHONE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
KNOWS WHAT TO DO IN AN EMERGENCY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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PART III: OTHER SERVICES

Please identify the other agencies or programs from which are currently receiving services or have received services from in the past by checking the appropriate box.

<u>AGENCY</u>	APPLIED	CURRENTLY SERVED	SERVED IN THE PAST	HAVE NOT APPLIED
Dept. of Social Services (DSS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Board of Education (Local School System)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Local Health Dept.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Area Office on Aging (AAA)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Div. of Rehabilitation Services (DORS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Health Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nursing Home Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assisted Living Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (Please List):				

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Please identify any other programs or services for which you have applied, currently receive or previously received.

PROGRAM	APPLIED	CURRENTLY SERVED	PREVIOUSLY SERVED
Autism Waiver	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Personal Care (Medicaid Service)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Living at Home Waiver	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical Day Care Waiver	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Waiver for Older Adults	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Model Waiver for Medically Fragile Children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
REM (Rare and Expensive Case Management Program)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Traumatic Brain Injury Waiver	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Are there any other agencies or programs not listed above that are helping you now, or that have you on a waiting list? Yes No

If yes, please list the agencies/programs.

NOTE:

DDA will review all the information you provide. Within seven (7) days DDA will make a preliminary decision as to whether there is a reasonable likelihood that you might be eligible for services from DDA or whether more information is needed. If necessary a representative of DDA will contact you to obtain further information or, if you agree by signing the consent form below, DDA can request information from other sources to help in its determination. DDA will make a final eligibility decision within 60 days of receipt of the completed application with all supporting documentation. You may request extensions of the time for processing, if additional time is needed to schedule a meeting with the DDA representative, or to obtain necessary evaluations and information. If you need help with this application, please call the Regional DDA office listed on page 1 of this form or call the Resource Coordination office for your county/region.

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PART IV: AUTHORIZATION TO REQUEST & RECEIVE SERVICES

In order to determine your eligibility and plan for services, DDA needs information from professionals and agencies that are familiar with your disability and service needs. The Request to Obtain Information from Professionals and Agencies form authorizes the Developmental Disabilities Administration to obtain information from the professionals and agencies listed on this application. **Please make copies, if needed, and complete one authorization form for each professional or agency to be contacted.**

Request to Obtain Information from Professionals and Agencies

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LAST Name

FIRST Name

MIDDLE Name

Date of Birth (MM/DD/YYYY):

Social Security Number:

I hereby give permission to the persons and/or agencies listed below to release any information they may have regarding my application to the Developmental Disabilities Administration (DDA) to assist them in determining my eligibility for services.. A photocopy of this authorization is valid.

Professional/Agency Name: _____ Phone Number: _____

Address: _____

Information is to be mailed to:

Regional Office Contact: _____ Phone Number: _____

Address: _____

Signature: _____ Date:

Printed Name: _____

Relationship to Applicant: _____

Witness: _____

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Additional contacts (Please list at least one additional contact)

	Name	Relationship to applicant	Phone number	E-mail
1.	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
2.	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
3.	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
4.	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
5.	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>

PART VI: STATISTICAL INFORMATION

Please complete the following information, which will be used for statistical purposes only.

Applicant's Sex:

- Female Male

Is the Applicant of:

- Hispanic Origin Latino Origin

Applicant's Race (more than one selection can be made):

- American Indian / Alaskan Native
 Asian
 Black / African American
 Native Hawaiian / Other Pacific Islander
 White

Applicant's Marital Status:

- Single Married
 Divorced Widowed

Applicant's Country of Origin: _____

Primary Spoken Language: _____

Additional Comments:

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PART VII: SIGNATURE SECTION

I swear or affirm that I have read or had read to me this entire application. I also swear or affirm, under penalty of perjury, that all the information I have given is true, correct, and complete to the best of my ability, knowledge and belief. I authorize the DDA to contact any person, partnership, corporation, association, or governmental agency that has provided information about my eligibility for benefits.

Notice to Applicants:

You are providing personal information (Name, Address, Date of Birth, etc.) in this application.

The purpose of requesting this personal information is to determine your eligibility for DDA services. If you do not provide this personal information, the DDA may deny your application. You have the right to inspect, amend or correct this personal information. The DDA will not permit inspection of your personal information, or make it available to others, except as permitted by federal and State laws.

Your Responsibilities are to Provide Information and to Report Changes:

You must give true and complete information. You must provide proof of this information. We will keep it private. We will use the social security number and other information you give us to do computer matching and program reviews. All changes must be reported within ten (10) days. Examples of such changes include: address, persons living in the applicant's home, or new services or change in services from another agency. You, your primary caregiver, legal guardian or contact person is responsible for reporting such changes. If you intentionally do not give correct information or report changes, services may be discontinued or legal action may be taken.

Signature of Applicant

Date

Signature of Authorized Representative

Date

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WHEN THE APPLICATION IS COMPLETE, SEND IT TO THE APPROPRIATE DDA REGIONAL OFFICE LISTED BELOW:

THE CENTRAL MARYLAND REGIONAL OFFICE

(Anne Arundel County, Baltimore County, Howard County, Harford County and Baltimore City)

ATTENTION: Eligibility and Access Unit

1401 Severn Street

Baltimore, MD 21230

THE EASTERN SHORE REGIONAL OFFICE

(Caroline County, Cecil County, Dorchester County, Kent County, Queen Anne's County, Somerset County, Talbot County, Wicomico County, Worcester County)

ATTENTION: Eligibility and Access Unit

926 Snow Hill Rd, Building 100

Salisbury, MD 21804

THE SOUTHERN MARYLAND REGIONAL OFFICE

(Calvert County, Charles County, Montgomery County, Prince George's County, and St. Mary's County)

ATTENTION: Eligibility and Access Unit

312 Marshall Avenue, 7th Floor

Laurel, MD 20707

THE WESTERN MARYLAND REGIONAL OFFICE

(Allegany County, Carroll County, Frederick County, Garrett County, and Washington County)

c/o Potomac Center

ATTENTION: Eligibility and Access Unit

1360 Marshall Street

Hagerstown, MD 21740

More Information about the Developmental Disabilities Administration may be found at the following website:

<http://dda.dhmh.maryland.gov>

The Developmental Disabilities Administration does not discriminate on the basis of race, color, sex, national origin, religion or disability in matters of employment or in providing access to programs.