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

LAST Name **FIRST Name** **MIDDLE Name**

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

Permanent Mailing Address:

Street Address	*Apt#*

City	*State*	*Zip Code*	*County of Residence*

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:** _____

PART II: APPLICANT SELF ASSESSMENT

Please check all disabilities that you have been diagnosed with:

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

Other: _____

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

- ☐ **Medical Records**
- ☐ **Neuropsychological Evaluations**
- ☐ **Psychological Evaluations**
- ☐ **Special Education Records**
- ☐ **Vocational Evaluations**
- ☐ **Other professional assessments**

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?
☐ I walk independently.	☐ I do not need assistance.
☐ I can walk unaided, but with difficulty.	☐ I need occasional assistance. Several hours per day up to 3 days per week.
☐ I require supportive devices when I walk.	☐ I need minimal daily assistance. 1-2 hours per day.
☐ I use a power wheelchair.	☐ I need substantial daily assistance. 8 hours or more per day.
☐ I use a manual wheelchair.	☐ I need continuous assistance when I am awake.
☐ I use a scooter.	☐ I need continuous 24 hours per day assistance.
☐ I am unable to move independently.	☐ Other.
☐ Other.	

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?
☐ I speak clearly and can be understood.	☐ Speech Therapy
☐ My speech is difficult to understand.	☐ Occupational Therapy
☐ I use gestures to communicate.	☐ Physical Therapy
☐ I use sign language to communicate.	☐ Specialized Medical Care
☐ I require a communication device to communicate.	☐ Behavioral Support Service
☐ I need help from others to communicate.	☐ Counseling
☐ Other: _____	☐ Psychiatric Treatment
	☐ Other: _____

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

PERSONAL SKILLS	COMPLETELY INDEPENDENT	NEEDS ASSISTANCE	COMPLETELY DEPENDENT
EATING	☐	☐	☐
DRESSING	☐	☐	☐
BATHING	☐	☐	☐
TOILETING	☐	☐	☐
GROOMING	☐	☐	☐
TRANSFERS IN/OUT OF BED	☐	☐	☐
PREPARES SIMPLE FOOD	☐	☐	☐
COMPLETES HOUSEHOLD TASKS	☐	☐	☐
USES PUBLIC TRANSPORTATION	☐	☐	☐
USES THE TELEPHONE	☐	☐	☐
KNOWS WHAT TO DO IN AN EMERGENCY	☐	☐	☐

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.

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

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	☐	☐	☐
Personal Care (Medicaid Service)	☐	☐	☐
Living at Home Waiver	☐	☐	☐
Medical Day Care Waiver	☐	☐	☐
Waiver for Older Adults	☐	☐	☐
Model Waiver for Medically Fragile Children	☐	☐	☐
REM (Rare and Expensive Case Management Program)	☐	☐	☐
Traumatic Brain Injury Waiver	☐	☐	☐

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.

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

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: _____

PART V: CARE GIVER/GUARDIAN CONTACT INFORMATION

*The primary **caregiver** is the person responsible for the applicant's daily care.*
*A **legal guardian** is appointed by the court and may or may not be the primary caregiver. A legal guardian should attach a copy of the guardianship order.*
*A **contact** person is the person who can assist the DDA in contacting the applicant and may be a friend, family member, or an agency contact.*

Please check any title that best describes the role of the person whose name and information is provided on this page: ☐ Primary Caregiver ☐ Legal Guardian ☐ Contact Person

LAST Name	**FIRST Name**	**MIDDLE Initial**

Permanent Mailing Address:

Street Address		***Apt#***	
City	***State***	***Zip Code***	***County of Residence***

Telephone: **Email:** _____

Day	
Cell	
Evening/Other	

Name of agency, if applicable, acting as the primary caregiver, legal guardian, or contact person:

_____

Please provide the following information regarding the primary caregiver only, if applicable:

Primary Caregiver's Date of Birth (MM/DD/YYYY):

Does the applicant reside with the primary caregiver? ☐ Yes ☐ No

Relationship to the Applicant:

☐ Self
☐ Family Member (please specify relationship): _____
☐ Not Related
☐ Public/Private Agency

Briefly describe any circumstances that may be causing difficulty for the primary caregiver.

Additional contacts (Please list at least one additional contact)

	Name	Relationship to applicant	Phone number	E-mail
1.				
2.				
3.				
4.				
5.				

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:

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

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.