

PLEASE RETURN TO: DDA Eastern Shore Regional Office
Attn: Eligibility Office
1500 Riverside Drive, Salisbury MD 21802
IF QUESTIONS CALL: 410-334-6920; toll free 1-888-219-0478

DEVELOPMENTAL DISABILITIES ADMINISTRATION

APPLICATION FOR SERVICE

FOR OFFICE USE ONLY

Regional Office: _____

Date Received: _____

Applicant I.D. Number: _____

PART I: APPLICANT'S INFORMATION

I-1. Applicant's Social Security Number: _____ - _____ - _____

I-2. Applicant's Medical Assistance Number: _____

____ Federal ____ State Start date: ____/____/____ End date: ____/____/____
(Currently all M.A is Federally Funded)

I-3. Applicant's Name: _____
Last First M.I.

I-4. Applicant's Permanent Mailing Address:

_____ P. O. Box No. Apt. No.

_____ City State Zip Code

I-5. Applicant's Telephone Number: (____) _____

Signature of Person Completing Application: _____ Date: _____

I-6. Applicant's County of Residence:

- | | | |
|-----------------------|---------------------------|------------------------|
| ____ (1) Allegany | ____ (10) Frederick | ____ (18) St. Mary's |
| ____ (2) Anne Arundel | ____ (11) Garrett | ____ (19) Somerset |
| ____ (3) Baltimore | ____ (12) Harford | ____ (20) Talbot |
| ____ (4) Calvert | ____ (13) Howard | ____ (21) Washington |
| ____ (5) Caroline | ____ (14) Kent | ____ (22) Wicomico |
| ____ (6) Carroll | ____ (15) Montgomery | ____ (23) Worcester |
| ____ (7) Cecil | ____ (16) Prince George's | ____ (30) Baltimore |
| ____ (8) Charles | ____ (17) Queen Anne's | ____ (40) Wash., D.C. |
| ____ (10) Dorchester | | ____ (50) Out-of-State |

I-7. Applicant's Date of Birth: Month: _____ Day: _____ Year: _____

I-8. Applicant's sex: _____ Male _____ female

I-9. Applicant's Race: _____ (1) Black _____ (2) White _____ (3) Native American
_____ (4) Asian _____ (5) Other

I-10. Applicant's Marital Status: _____ (1) Single _____ (2) Married
_____ (3) Divorced _____ (4) Widowed

I-11. Onset of disability before age 22: _____ (1) Yes _____ (2) No

I-12 Applicant's disability (disabilities):

From the list below, enter the codes of the applicant's disability (disabilities) in priority order up to six in the spaces provided.

(1) _____ (2) _____ (3) _____
(4) _____ (5) _____ (6) _____

- | | |
|---|------------------------------------|
| (00) Not available | (12) Mental retardation |
| (01) None | (13) Multiple sclerosis |
| (02) Autism | (14) Muscular dystrophy |
| (03) Behavioral problems | (15) Orthopedic Impairment |
| (04) Blindness/Severe visual impairment | (16) Specific learning disability |
| (05) Cerebral palsy | (17) Speech/Language impairment |
| (06) Chemical dependency
(Includes alcoholism) | (18) Spina bifida |
| (07) Cystic fibrosis | (19) Spinal cord injury |
| (08) Deafness/Severe hearing impairment | (20) other neurological impairment |
| (09) {Reserved} | (21) Undetermined |
| (10) Epilepsy/Seizure disorder | (22) others |
| (11) Head injury | (23) Mental Disorder |
| | (24) AIDS |

I-13. Applicant's Mobility:

- ___ (1) Walks independently
- ___ (2) Walks with supportive devices
- ___ (3) Walks unaided with difficulty
- ___ (4) In wheelchair operated by self
- ___ (5) In wheelchair & needs help
- ___ (6) No mobility

I-14. Applicant's need for supervision

- ___ (1) No supervision
- ___ (2) Occasional monitoring
- ___ (3) Minimal daily supervision
- ___ (4) Substantial daily supervision
- ___ (5) Continuous supervision during waking hours
- ___ (6) Continuous 24 hours per day supervision
- ___ (7) Not sure

I-15. Applicant's ability to communicate:

- ___ (1) Speaks and can be understood
- ___ (2) Speaks and is difficult to understand
- ___ (3) Uses gestures
- ___ (4) Uses Sign Language
- ___ (5) Uses communication board or device
- ___ (6) None

I-16. Applicant's functioning level:

- ___ (0) No entry
- ___ (1) Mild
- ___ (2) Moderate
- ___ (3) Severe
- ___ (4) Profound
- ___ (5) Unknown

I-17. Applicant's skill in activities of daily living:

	Completely Independent	Needs Assistance	Completely Dependent
	(1)	(2)	(3)
A. Eating.....	_____	_____	_____
B. Dressing.....	_____	_____	_____
C. Bathing.....	_____	_____	_____
D. Toileting.....	_____	_____	_____
E. Hygiene.....	_____	_____	_____
F. Transfers in/out of bed.....	_____	_____	_____

PART II: CAREGIVER/GUARDIAN/NEXT-OF-KIN INFORMATION

The primary caregiver is the person responsible for the applicant's daily care. If the applicant is in a residential facility, put down the name of the contact person.

II-1. Primary caregiver's name: _____
Last First M.I.

II-2. Primary caregiver's permanent mailing address:

P. O. Box No. Apt. No.

City State Zip Code

II-3. Telephone: (_____) _____

II-4. County of residence:

- | | | |
|-----------------------|---------------------------|------------------------|
| ____ (1) Allegany | ____ (10) Frederick | ____ (18) St. Mary's |
| ____ (2) Anne Arundel | ____ (11) Garrett | ____ (19) Somerset |
| ____ (3) Baltimore | ____ (12) Harford | ____ (20) Talbot |
| ____ (4) Calvert | ____ (13) Howard | ____ (21) Washington |
| ____ (5) Caroline | ____ (14) Kent | ____ (22) Wicomico |
| ____ (6) Carroll | ____ (15) Montgomery | ____ (23) Worcester |
| ____ (7) Cecil | ____ (16) Prince George's | ____ (30) Baltimore |
| ____ (8) Charles | ____ (17) Queen Anne's | ____ (40) Wash., D.C. |
| ____ (10) Dorchester | | ____ (50) Out-of-State |

II-5. Caregiver's Date of Birth: Month: _____ Day: _____ Year: _____

II-6. Relationship to applicant:

- | | | |
|----------------------|--------------------------------|---------------------|
| ____ (1) Parent | ____ (4) Other relative | ____ (7) DDA Agency |
| ____ (2) Spouse | ____ (5) Self | |
| ____ (3) Not related | ____ (6) Public/Private Agency | |

GUARDIAN

If the legal guardian appointed by the court is not the primary caregiver, complete the following section:

II-7. Guardian's name: _____

II-8. Guardian's permanent mailing address:

P. O. Box No.	Apt. No	
_____	_____	_____
City	State	Zip Code

II-9. Telephone: (_____) _____

II-10. County of Residence:

- | | | |
|-----------------------|---------------------------|------------------------|
| ____ (1) Allegany | ____ (10) Frederick | ____ (18) St. Mary's |
| ____ (2) Anne Arundel | ____ (11) Garrett | ____ (19) Somerset |
| ____ (3) Baltimore | ____ (12) Harford | ____ (20) Talbot |
| ____ (4) Calvert | ____ (13) Howard | ____ (21) Washington |
| ____ (5) Caroline | ____ (14) Kent | ____ (22) Wicomico |
| ____ (6) Carroll | ____ (15) Montgomery | ____ (23) Worcester |
| ____ (7) Cecil | ____ (16) Prince George's | ____ (30) Baltimore |
| ____ (8) Charles | ____ (17) Queen Anne's | ____ (40) Wash., D.C. |
| ____ (10) Dorchester | | ____ (50) Out-of-State |

II-11. Relationship to applicant:

- | | | |
|----------------------|--------------------------------|---------------------|
| ____ (1) Parent | ____ (4) Other relative | ____ (7) DDA Agency |
| ____ (2) Spouse | ____ (5) Self | |
| ____ (3) Not related | ____ (6) Public/Private Agency | |

NEXT-OF-KIN

If the next-of-kin is not the primary caregiver or the legal guardian appointed by the court, complete the following section:

II-12. Next-of-kin's name: _____

II-13. Next-of-kin's permanent mailing address:

P. O. Box No.	Apt. No	
_____	_____	_____
City	State	Zip Code

II-14. Telephone: (_____) _____

II-15. County of Residence:

- | | | |
|-----------------------|---------------------------|------------------------|
| ____ (1) Allegany | ____ (10) Frederick | ____ (18) St. Mary's |
| ____ (2) Anne Arundel | ____ (11) Garrett | ____ (19) Somerset |
| ____ (3) Baltimore | ____ (12) Harford | ____ (20) Talbot |
| ____ (4) Calvert | ____ (13) Howard | ____ (21) Washington |
| ____ (5) Caroline | ____ (14) Kent | ____ (22) Wicomico |
| ____ (6) Carroll | ____ (15) Montgomery | ____ (23) Worcester |
| ____ (7) Cecil | ____ (16) Prince George's | ____ (30) Baltimore |
| ____ (8) Charles | ____ (17) Queen Anne's | ____ (40) Wash., D.C. |
| ____ (10) Dorchester | | ____ (50) Out-of-State |

II-16. Relationship to applicant:

- | | |
|-----------------|-------------------------|
| ____ (1) Parent | ____ (3) {Reserved} |
| ____ (2) Spouse | ____ (4) Other relative |