PLEASE RETURN TO: Gail Singletary, Eligibility Unit
Southern Maryland Regional Office
312 Marshall Avenue, Suite 700
Laurel, Maryland 20707
IF QUESTIONS CALL: 301-362-5100; toll free 1-888-207-2479
TDD 301-362-5131

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
____ (2) Anne Arundel
____ (3) Baltimore
____ (4) Calvert
____ (5) Caroline
____ (6) Carroll
____ (7) Cecil
____ (8) Charles
____ (9) Dorchester
____ (10) Frederick
____ (11) Garrett
____ (12) Harford
____ (13) Howard
____ (14) Kent
____ (15) Montgomery
____ (16) Prince George's
____ (17) Queen Anne's
____ (18) St. Mary's
____ (19) Somerset
____ (20) Talbot
____ (21) Washington
____ (22) Wicomico
____ (23) Worcester
____ (30) Baltimore
____ (40) Wash., D.C.
____ (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
(01) None
(02) Autism
(03) Behavioral problems
(04) Blindness/Severe visual impairment
(05) Cerebral palsy
(06) Chemical dependency (Includes alcoholism)
(07) Cystic fibrosis
(08) Deafness/Severe hearing impairment
(09) {Reserved}
(10) Epilepsy/Seizure disorder
(11) Head injury
(12) Intellectual Disability
(13) Multiple sclerosis
(14) Muscular dystrophy
(15) Orthopedic Impairment
(16) Specific learning disability
(17) Speech/Language impairment
(18) Spina bifida
(19) Spinal cord injury
(20) other neurological impairment
(21) Undetermined
(22) others
(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 (1)	Needs Assistance (2)	Completely Dependent (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.
____ (9) 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.
____ (9) 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.
____ (9) Dorchester		____ (50) Out-of-State

II-16. Relationship to applicant:

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