

PLEASE RETURN TO: DDA-CENTRAL MARYLAND REGIONAL OFFICE
1401 Severn Street
Suite 200
Baltimore, MARYLAND 21230
IF QUESTIONS CALL: 410-234-8200; Toll Free: 1-877-874-2494

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:

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 City |
| (8) Charles | (17) Queen Anne's | (40) Wash., D.C. |
| (9) 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) Intellectual Disability |
| (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) Spinal 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.....			

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:

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 City |
| (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:

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 City |
| (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 |

PERSONS WITH DEVELOPMENTAL DISABILITIES
APPLICATION FOR SERVICES

REFERRAL FORM

This referral form should be used to refer a person with a developmental disability for consideration for services from the Developmental Disabilities Administration of the Maryland Department of Health and Mental Hygiene. If an Application for Services does not accompany this referral form it will be sent to you. Please complete this referral form. PLEASE PRINT OR TYPE. Thank you.

NOTE: THE APPLICANT IS THE PERSON WITH THE DISABILITY.

Date Referral Form was completed: _____

Name of Applicant: _____

Social Security Number of Applicant: _____

Date of Birth of Applicant: _____

Name of Caregiver (if applicable): _____

Address of Applicant/Caregiver: _____

_____ County

Telephone Number of Applicant/Caregiver: _____

Day Evening

Name of Person Making Referral: _____

Name of Referral Agency: _____

Address of Referral Agency: _____

Telephone Number of referral Agency: _____

If you are requesting feedback on the application submitted you must be listed on the signed authorization form. Are you requesting information? YES NO

Request to Obtain Information from Professionals and Agencies

In order to verify eligibility and plan for services we may need information from professionals and agencies that are familiar with the disability and service needs of the applicant. The release of information form authorizes the Developmental Disabilities Administration to obtain information from professionals and agencies listed.

AUTHORIZATION TO REQUEST AND RECEIVE INFORMATION

Applicant's Name: _____

Social Security Number: _____ - _____ - _____ Date of Birth: ____/____/____

I hereby give permission to the person and/or agencies listed below to release any information they may have regarding the applicant to the Developmental Disabilities Administration (DDA) to assist in determining eligibility for services for the applicant.

1. Name: _____ Phone Number: _____

Address: _____

2. Name: _____ Phone Number: _____

Address: _____

3. Name: _____ Phone Number: _____

Address: _____

Signature: _____ Date: ____/____/____

Printed Name: _____

Relationship to Applicant: _____

Witness: _____

RELEASE OF INFORMATION FORM

Do you want someone (other than yourself) kept informed of the status of your application?
YES NO

If the answer is no, we will not release information regarding the status of your application to anyone other than you outside of the Developmental Disabilities Administration (DDA).

If the answer is yes, please fill out this form completely. This authorizes the DDA to inform only those you indicate of the status of your application as it is processed. If you complete this form the agencies or people you list will receive copies of all letters sent to you regarding your application. **Do not complete this form unless you want someone to know about the status of your application for referral to agencies for services.**

AUTHORIZATION FOR RELEASE OF INFORMATION REGARDING APPLICATION FOR SERVICES

Applicant's Name: _____

Social Security Number: _____ - _____ - _____ Date of Birth: ____/____/_____

I authorize the Developmental Disabilities Administration (DDA) to release information regarding the status of the application for services for the above named applicant.

1. Name: _____ Phone Number: _____
Address: _____

2. Name: _____ Phone Number: _____
Address: _____

3. Name: _____ Phone Number: _____
Address: _____

Signature: _____ Date: ____/____/_____
Printed Name: _____
Relationship to Applicant: _____
Witness: _____

