

**PLEASE RETURN TO:** DDA - WESTERN REGIONAL OFFICE  
1360 MARSHALL STREET  
HAGERSTOWN, MARYLAND 21740  
IF QUESTIONS CALL: 301-791-4670; toll free 1-888-791-0193

# 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-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:

\_\_\_\_\_

\_\_\_\_\_

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 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:

\_\_\_\_\_

\_\_\_\_\_

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 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 |

## Request to Obtain Information from Professionals and Agencies

In order to verify eligibility and plan for services we may need information from professional 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.

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### AUTHORIZATION TO REQUEST AND RECEIVE INFORMATION

Applicant's Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

I hereby give permission to the persons 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: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

(PLEASE COMPLETE OTHER SIDE IF MORE THAN TWO PERSONS/AGENCIES)

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Printed Name: \_\_\_\_\_

Relationship to Applicant: \_\_\_\_\_

Witness: \_\_\_\_\_

