DELAWARE DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES
ELIGIBILITY CRITERIA

The Division of Developmental Disabilities Services provides services to those individuals whose disability meets all of the following conditions:

(A) (i) is attributable to mental retardation (1992 AAMR definition) and/or (ii) Autism (DSM IV)and/or (iii) Prader Willi (documented medical diagnosis) and/or (iv) brain injury (individual meets all criteria of the 1992 AAMR definition including age manifestation) and/or (v) is attributable to a neurological condition closely related to mental retardation because such condition results in an impairment of general intellectual functioning and adaptive behavior similar to persons with mental retardation and requires treatment and services similar to those required for persons with impairments of general intellectual functioning:

(B) is manifested before age 22

(C) is expected to continue indefinitely;

(D) results in substantial functional limitations in 2 or more of the following adaptive skill areas

1) communication;
2) self-care;
3) home living;
4) social skills;
5) community use;
6) self-direction;
7) health and safety;
8) functional academics;
9) leisure;
10) work; and

(E) reflects the need for lifelong and individually planned services.

Intellectual functioning and adaptive behavior is determined by using established standardized tests approved by the Division.

Effective 7-10-2000

CONFIDENTIAL

Application

Part I- Clinical Determination

INFORMATION ABOUT YOU (the person making application)

Name:	MCI Number *(for office use only)*:
Address:	Birth Date:
City: State: Zip:	Social Security #:
Phone Number:	Gender (Male/Female):
E-Mail Address:	

This information is for demographic purposes only. This will not be used for eligibility determination.

Race/Ethnicity	☐ White/Caucasian ☐ Black/African American ☐ Hispanic ☐ Pacific Islander	☐ Asian ☐ Native American ☐ Other (specify):
Religious Preference	☐ Christian ☐ Islamic ☐ Hindu	☐ Jewish ☐ Buddhist ☐ Other (specify)

Citizenship and Residency Information: (The following information will be used for determination purposes)

Is the applicant a citizen or lawful alien of the United States of America? _____ Yes _____ No (If a lawful alien, the applicant must produce documentation of their alien status)
Is the applicant a resident of the State of Delaware? _____ Yes _____ No

Health Insurance

Insurance Company: Name of Policy Holder: Policy Number:	Address of Insurance Company:
Medicaid Number:	Blood Bank Member ☐ YES ☐ NO Policy/Acct. Number:
Medicare Number:	☐ Part A ☐ Part B
Medicaid Managed Care Provider:	Medicare Prescription Plan (Part D)
Medicare Supplemental Plan: Provider/Acct. Number:	

INFORMATION ABOUT YOU & PEOPLE WHO KNOW AND CARE FOR YOU

(This information will help us to contact your family and other important people)

Who is your primary support person/care giver(s)?

Name	Relationship	Date of Birth	Address	Phone Number

Parents

Name of Mother:	Name of Father:
Mother's Date of Birth: Mother's Date of Death:	Father's Date of Birth: Father's Date of Death:
Mother's Social Security #:	Father's Social Security #:

Other Family Members (brothers, sisters, half-siblings, grandparents)

Name	Relationship	Date of Birth	Date of Death	Address	Phone Number

Emergency Contact Person(s)

Name	Relationship	Address	Phone Number

Does anyone come into your home to help you? ☐YES ☐ NO

If yes, what is the name of the support agency or person who helps you in your home? _____

Address: _____

Phone Number(s): _____

Is someone assigned as your guardian of ☐ Person ☐ Property
If yes, please attach a copy of the guardianship order with this application.

Guardian Information

Name of Guardian	Relationship to You	Date of Court Order	Address	Phone Number(s)

Do you have **advanced directive**? ☐ Yes ☐ No
If yes, please attach a copy with this application.

Have you established a **Power of Attorney**? ☐ Yes ☐ No
If yes, please attach a copy with this application.

Name of Power of Attorney	Relationship to You	Address	Phone Number(s)

ABOUT YOUR BIRTH

Were there any difficulties with your birth (example: cord wrapped around neck, breech birth)? ☐ Yes ☐ No
If yes, please explain: _____

Were you: ☐ Full Term ☐ Premature (how many months was your mother pregnant with you?) _____

Was anesthesia used during your birth? ☐ Yes ☐ No ☐ Not Sure

Were instruments used? ☐ Yes ☐ No ☐ Not Sure

Did you cry at once? ☐ Yes ☐ No ☐ Not Sure

Did you require special treatment to help you breathe (injections, oxygen, etc.)? ☐ Yes ☐ No ☐ Not Sure

What was your weight at birth? _____

What was your Apgar score (if known)? _____

ABOUT YOUR DEVELOPMENT

Did you receive early childhood intervention services? ☐ Yes ☐ No

If so, when did you receive the early childhood intervention services? _____

Where did you receive the early childhood intervention services? _____

Please tell us how old you were when the following developmental milestones happened for the first time?

Teething _____ Sitting Alone _____ Standing Alone _____

Walking Alone _____ Beginning to talk _____ Toilet Trained _____

SCHOOL HISTORY

Where did you last (or currently) attend school?

Name of School	Address	Phone Number	Contact Person	Last Grade Attended	Dates Attended

Did you receive special education services? ☐ Yes ☐ No

If yes, what was your Special Education classification (if known)? _____

Did you receive a Certificate of Attendance? ☐ Yes ☐ No If yes, what year? _____

Did you receive a diploma? ☐ Yes ☐ No If yes, what year? _____

CRIMINAL HISTORY

Have you ever been convicted of a criminal offense? ☐ Yes ☐ No

If yes, please tell us the following information:

Conviction	Sentence	Location	Date

Are you currently on parole or probation?

If yes, please tell us the following information:

Condition(s) of Probation or Parole	Name of Probation/Parole Officer	Address of P/P Officer	Phone Number of P/P Officer

WORK HISTORY

Where Have You Worked	Describe The Work You Did	When Did You Work There (give dates)?

SERVICE HISTORY

Do you or have you received services from any of the following?

	Current	Past		Current	Past
Adult Protective Services			DDDS Community Programs		
A.I. DuPont Hospital			Governor Bacon		
Alcohol/Drug Rehab			Meadowood Hospital		
ARC			Mental Health Outpatient Services Location:		
Child Mental Health			Nemours Children's Clinic		
Community Legal Aid			Rockford Center		
Delaware Autistic Program			Stockley Center		
Delaware Psychiatric Hospital			Terry Center		
Division of Family Services			Vocational Rehabilitation Location:		
Division of Visually Impaired			St. Jones Hospital/Treatment Center		
Division of Youth Rehabilitation			Division of Services for Aging and Adults with Physical Disabilities		
Other:			Other:		

Are you now or have you ever received day or residential services in Delaware or any other state? ☐ Yes ☐ No

If yes, please tell us the following information:

Name of Residential/Day Program Attended	Address	Phone	Dates Attended	Contact Person

LAST PSYCHOLOGICAL EVALUATION

When was your most current psychological evaluation completed (date)? _____

Who tested you? _____

Where was the psychological evaluation completed (address)? _____

PSYCHIATRIC HISTORY

Have you ever received out-patient psychiatric/mental health treatment in Delaware or any other state? ☐Yes ☐No

If yes, please tell us the following information:

Name of Clinician	Address of Clinician or Treatment Center	Date of Treatment

Have you ever received in-patient psychiatric treatment in Delaware or any other state? ☐Yes ☐No?

If so, please tell us the following information:

Name of Psychiatrist	Address of Psychiatrist or Treatment Center	Date of Treatment

MEDICAL INFORMATION:

Please list your current medical diagnosis/health problems: _____

_____

_____

_____

Please list your current psychiatric/mental health diagnosis: _____

_____

Name	**Address**	**Phone**	**How Often Seen?**
Family Doctor:			
Psychiatrist:			
Psychologist:			
Dentist:			
Hospital Preference:			
Other Doctors: 1. _____ 2. _____ 3. _____ 4. _____			

☐ I take my medicine by myself. ☐ I need help/reminders to take my medicine.

Please tell us about ALL the medicines that you are taking including prescription and non-prescription. (For example, aspirin, suppositories, supplements, vitamins).

Name of Medication: _____

□ Prescription □ Non-Prescription

Reason for medication: _____

How do you take it (describe any help you may need)? _____

Name of Medication: _____
□ Prescription □ Non-Prescription

Reason for medication: _____

How do you take it (describe any help you may need)? _____

Name of Medication: _____
□ Prescription □ Non-Prescription

Reason for medication: _____

How do you take it (describe any help you may need)? _____

Name of Medication: _____
□ Prescription □ Non-Prescription

Reason for medication: _____

How do you take it (describe any help you may need)? _____

Name of Medication: _____
□ Prescription □ Non-Prescription

Reason for medication: _____

How do you take it (describe any help you may need)? _____

Do you have or have you ever had a seizure? ☐ Yes ☐ No

Describe your serizures:_____

How often do you have seizures? _____

How long do they last? _____

How do you feel after a seizure? _____

How do people who know you best support you during a seizure?_____

Part II- Waiver Eligibility and Enrollment

FINANCIAL

Who manages your money? ☐ Self ☐ Other: Name & Relationship of Person _____

Do you have a representative payee? ☐ Yes ☐ No

Please tell us the following information about your representative payee, if applicable:

Name	Address	Phone Number(s)

Income Information
Please provide verification of each source of income and resources

All Sources of Earned and Unearned Income	Monthly Amount	Did you include verification?
SSI		
SSDI/OASDI		
VA Benefits		
Railroad Benefits		
Pension (company name:_____)		
Wages		
Child Support		
Public Assistance		
Other (Please specify): _____		

	Account Number	Name of Bank	Current Balance	Verification Enclosed?
Checking Account				
Savings Account				
Certificate of Deposit (CD's)				
Credit Union Account				
Money Market Account				
Mutual Funds Account				
Stocks				
Bonds				

Trust Fund: Trustee's Name: _____
Trustee's Phone Number: _____
Value of Trust Fund: _____
Name of Financial Institution: _____

Other Funds (Income or Resources): Type: _____
Value: _____

Life Insurance

Name of Person Insured	
Policy Owner	
Insurance Company	
Company Address	
Face Value of Policy	
Table of Cash Surrender Value	
Name of Beneficiary	

Do you have a pre-paid funeral arrangement? ☐ Yes ☐ No

Copies of the following highlighted documents must be provided in order to process your application. All other documents must be provided if it applies to you. Processing of your application cannot begin until all required documents and information are received.

Required Documentation	Indicate the document provided as verification	Date Provided
Birth Certificate		
Social Security Card		
Verification of Delaware Residence		
Proof of U.S. Citizenship		
Lawful Alien Documentation		
Comprehensive Physical (MAP-25)		
ICAP Information List		
Private Health Insurance Card		
Medicaid/Medicare Card		
Guardianship Order		
Advanced Directive		
Living Will		
Power of Attorney Order		
Pre-paid Funeral Arrangement		
Life Insurance Policies with table of cash surrender values		
Verification of wages for most recent 3 months		
Bank Statements for each account for the most recent 3 months		
Statements for all Certificate of Deposits, Money Markets, Mutual Funds for most recent 3 months		
Copy of Stocks and most recent 3 months statement		
Copy of Bonds with Maturity Schedule attached		
Verification of unearned income for most recent 3 months		
Verification of earned income for most recent 3 months		
Copy of Social Security/SSI Award Letters		

May a representative from DDDS leave a telephone message on your recorder/voice mail? ☐ Yes ☐ No

May a representative from DDDS leave a telephone message with a person at your home or business? ☐ Yes ☐ No

May a representative from DDDS contact you via the e-mail address on page one of this application? ☐ Yes ☐ No

I certify that I have provided true and complete answers to the questions on this application for DDDS services, to the best of my knowledge. I understand that providing false information for government subsidized benefits is punishable by law.

Person helping you to complete this application: _____ Phone: _____

Name of person providing information: _____ Phone: _____

Date of Completion: _____

Required Signatures:

Signature of Individual Applying for Services: _____

Signature of Guardian/Family Member (if applicable): _____

Final Review:

Signature of Director of Applicant Services:_____

POLICY OF THE STATE OF DELAWARE AS ESTABLISHED BY STATE LAW AND EXECUTIVE ORDER ASSURES EQUAL OPPORTUNITY AND PROHIBITS DISCRIMINATION ON THE BASIS OF RACE, RELIGION, COLOR, ORIGINAL ORGIN, SEX OR AGE.

PARC Approved: 11/06/03
Date Revised: 02/07/07
Form #: 09/Admin

DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES

AUTHORIZATION FOR RELEASE OF INFORMATION
APPLICANT SERVICES UNIT

Applicant: _____ D.O.B. _____ SS# _____

I, _____ hereby authorize the following agencies indicated below to release
Applicant/Guardian/Parent

and send information to The Division of Developmental Disabilities Services at Woodbrook Professional Center, 1052 South Governor's Avenue, Suite 101, Dover, Delaware 19904 or fax number (302) 744-9711.

A. I. duPont Hospital for Children	Yes ____	No ____
Child Development Watch	Yes ____	No ____
Division of Child Mental Health	Yes ____	No ____
Division of Adult Mental Health	Yes ____	No ____
Division of Vocational Rehabilitation	Yes ____	No ____
Delaware Autistic Program	Yes ____	No ____
Delaware Psychiatric Center	Yes ____	No ____
Division of Family Services	Yes ____	No ____
Meadowood Hospital	Yes ____	No ____
School _____	Yes ____	No ____
Rockford Center	Yes ____	No ____
Terry Center	Yes ____	No ____
Other: _____	Yes ____	No ____

This release of information is for the purpose of determining an applicant's eligibility for DDDS services and to assist in planning for services.

The type of information to be released is not limited and is to specifically include any history (social, behavioral, developmental, psychiatric) medical evaluations, psychological testing, consultations and discharge summaries.

The dates of service to be covered by this authorization include all years of services received/admissions.

I understand that this authorization is valid for one (1) year from the date signed, and that I may revoke this authorization by written communication to the Director of Applicant Services at the Woodbrook Professional Center, 1052 South Governor's Avenue, Suite 101, Dover, DE 19904.

Disclosure of specific information authorized for release is limited to the above-mentioned applicant only. Federal regulations 42 CFR Part 2 prohibits the redisclosure of information, unless the consent expressly permits further disclosure or is otherwise permitted under regulation.

_____ _____
Applicant Signature (if over age 18)/Guardian **Date**

_____ _____ _____
Parent/Guardian/Legally Authorized Person **Date** **Relationship to Applicant**

This Authorization must be signed by the applicant (if over the age of 18) or his/her court appointed guardian/legally authorized person. In the case of a minor, a parent or court appointed custodian must sign this Authorization.

PARC Approved: 05/02/03
Revised: 02/07/07
Form: #02/Admin

DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES

AUTHORIZATION FOR RELEASE OF INFORMATION ADDENDUM
APPLICANT SERVICES UNIT

It may be necessary to speak with various agency personnel regarding your application and the records that we need in order to determine your eligibility for Division of Developmental Disabilities Services (DDDS). In addition, several other agencies sometimes have a need to know the status of your application and your eligibility for DDDS services. Below are listed those agencies with which we are in frequent contact. By checking the appropriate box you can let us know if you object to our discussing your application and eligibility for services. If approved, we will limit our exchange to information that is necessary in assisting you with services and will be kept in strictest confidence. This Authorization will remain in effect for one year from the date of signature.

	Approve	**Disapprove**
Personnel at the School(s) you attended	☐	☐
Voc Rehab Counselor	☐	☐
Division of Family Services/Child Mental Health	☐	☐
Health Care Provider	☐	☐

I have read the information on this page and/or had it read to me and explained in a language I can understand. I understand my confidentiality rights.

_____ _____
(APPLICANT/GUARDIAN/LEGALLY AUTHORIZED PERSON'S SIGNATURE) (DATE SIGNED)

_____ _____
(OFFICE OF APPLICANT SERVICES STAFF PERSON'S SIGNATURE) (DATE SIGNED)

PARC Approved: 05/00/02
Revised: 02/007/07
Form: 01/Admin

DELAWARE HEALTH AND SOCIAL SERVICES
CONFIDENTIALITY NOTICE TO APPLICANTS

We want you to know why we need to collect information about you and your family, the steps we take to protect your privacy, and your rights to know what information we will keep in our records.

Please ask us for more details if you have any questions.

Why do we keep records? Delaware laws authorize the Department to collect and keep information we need to carry out our duties. This information is important for planning how to best work with you and your family.

Who else may learn this information? For the most part, only Department staff are permitted to know this information, unless you give us written permission to share it with someone else. If you are working with a team of people from different agencies within the Department, information may be shared among the team. The law requires us to share information in some other situations, such as court orders; emergencies threatening health or safety; and investigation of waste, abuse, or fraud.

Will Department staff keep this information confidential? All of our staff sign a confidentiality agreement, which clearly describes their duty to protect the privacy of all of our clients. In addition, the ethical codes of physicians, psychologists, nurses and social workers require them to keep information shared with them confidential.

Information shared with licensed physicians, psychologists and social workers cannot be subpoenaed, with the following exceptions: hospitalization proceedings: court ordered examinations; proceedings in which a guardian is sought, if the condition of the individual receiving services is part of the individual's legal claim or defense; and alleged child/impaired adult abuse or neglect cases.

Where is information stored? When not in use, all written records about you are kept under lock. Some information about you may be stored on a computer system. We protect information stored in computers by "locking-out" all but the staff authorized to learn that information.

What are your rights? You have a right to find out what records we keep about you, how they will be used, and how they will be shared with others. You also have a right to review your records, except for certain confidential information and investigative files. If you object to or do not agree with the information in our records, you may ask us to change our records.

If we decide that we cannot change the records, you may give us your information in writing, and we will put it in the records.

What if you have other questions? Please ask the staff person working with you if you have any other questions. If you ask, we will give you a copy of our policy on confidentiality.

DELAWARE HEALTH
AND SOCIAL SERVICES
Division of Developmental
Disabilities Services

FINANCIAL RESPONSIBILITY NOTICE

I understand that I may have some financial responsibility for the cost of services provided by the State of Delaware, Department of Health and Social Services, Division of Developmental Disabilities Services, as established by 29 Del. C §7940.

In order to determine any financial responsibility for the services I receive, I will be asked to disclose all information with regard to my financial status and assets including any jointly held financial accounts or accounts bearing my name.

The parents of a minor child receiving services may be asked to disclose their financial status and assets in order to determine any financial obligations and responsibilities they may have for the services provided to their child.

Financial resources received by the Division of Disabilities Services (DDDS) for an individual will be applied to the costs of the service(s) received in accordance with applicable Social Security, Medicaid and State rules and regulations.

Each individual receiving services has the responsibility of informing the DDDS of any changes in their financial status. Periodic updates of an individual's financial status and assets may be necessary during the receipt of services in order to ASCess the individual's financial responsibility and ensure continued eligibility for federal benefit programs.

Failure to fully disclose one's financial status and assets may result in a denial or loss of services.

I have read and understand the above notice and agree to assist the DDDS in determining any financial obligations I may have for services I receive.

_____ _____
Signature of Applicant Date

_____ _____
Signature of Parent (if applicant is a minor) or Substitute Decision-Maker /Legal Guardian (if applicable) Date

_____ _____
Witness Date

PARC Approved: 02/10/04
26/Admin