**APPLICATION FOR DDDS SERVICES**

**I certify that I am the: (select one)**

|  |
| --- |
| applicant, age 18 or older without a legal guardian  legal parent or guardian of the applicant, under age 18 Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  legal guardian of the adult applicant, age 18 or older Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

I have previously applied for DDDS Services  Yes  No  I don’t know

|  |  |
| --- | --- |
| Applicant Last Name: First Name: Preferred Name: | |
| Date of Birth: Age: Social Security #:  (MM/DD/YYYY) |  |
| Gender:  Male  Female Identifies as:  Male  Female  Non-binary  Transgender Male  Transgender Female  Declined to answer  Other: |  |
| *\*Attach copy of Birth Certificate, Social Security Card, and Medicaid Card (if applicable)* | |

**APPLICANT CONTACT INFORMATION**

|  |  |
| --- | --- |
| Mailing Address: |  |
| City: State: Zip Code: |  |
| Phone Number:  Cell  Home  Work |  |
| Alternate Phone Number:  Cell  Home  Work | |
| Email Address: | |

**PARENT/GUARDIAN CONTACT INFORMATION** (if applicable): Check if same as above

|  |  |
| --- | --- |
| Mailing Address: |  |
| City: State: Zip Code: |  |
| Phone Number:  Cell  Home  Work |  |
| Alternate Phone Number:  Cell  Home  Work | |
| Email Address: | |
| If applicant does not have a guardian, does the applicant have a **substitute decision maker** who can help with making healthcare decisions?  Yes  No  If yes, provide name and contact information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

**Applicant Race** (select all that apply) **Ethnicity**

American Indian/Alaska Native  White  Hispanic or Latino

Asian  Other  Non-Hispanic or Latino

Black or African American  Unknown  Unknown/Declined

Native Hawaiian/Pacific Islander  Declined

**Applicant Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DIAGNOSTIC INFORMATION NECESSARY TO DETERMINE ELIGIBILITY**

*(The following information is requested as part of the review process)*

Have you been diagnosed with any of the following? (must check yes for at least one option)

|  |  |  |  |
| --- | --- | --- | --- |
| Yes |  | No |  |
|  |  |  | Intellectual Disability |
|  |  |  | Autism Spectrum Disorder |
|  |  |  | Prader Willi Syndrome |
|  |  |  | Brain Injury that occurred prior to age 22 |

If yes to any of the above, please attach a copy of all supporting documentation, including any standardized psychological testing or assessment for verification. The standardized testing or assessment must have been completed prior to age 22 to be used to determine eligibility.

**CITIZENSHIP AND RESIDENCY INFORMATION**

*(The following information will be used for eligibility determination purposes.)*

|  |
| --- |
| Is applicant a citizen of the United States of America?  Yes  No |
| Is applicant a lawful alien of the United States of America?  Yes  No  N/A  (If a lawful alien, you must provide documentation of your lawful status.) | |
| Is applicant a resident of the State of Delaware?  Yes  No  Possible residency documentation includes:   * Valid Delaware State Driver’s license or ID issued by the Department of Motor Vehicles * Other Delaware picture ID card that includes applicant’s residential address issued by a city or county agency * Recent pay stub, telephone or utility bill with address, or current lease or mortgage * Copy of current Individualized Education Plan (IEP) that includes the student’s DE address | |

**ADDITIONAL QUESTIONS**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Preferred Language of Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Preferred Language of Family (if different than applicant): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Interpreter Services Needed (if we need to contact you)?  Yes  No  Applicant communicates: Verbally  Yes  No In writing  Yes  No  **Applicant Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**    How did you find out about DDDS? (check all that apply)   |  |  |  | | --- | --- | --- | | Family or Friend | School | Medical Professional | | Other State Agency | Internet/social media | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |   May a representative from DDDS leave a telephone message on the voice mail at the number(s) provided?  Yes  No | |  |  |  |  |
| May a representative from DDDS contact the applicant, parent, guardian, and person assisting the applicant via the email addresses on this application?  Yes  No |  | |  |  |  |

*I understand that this application is to determine eligibility for DDDS services. I certify that to the best of my knowledge I have provided true and complete answers to the questions. I understand that providing false information for government subsidized benefits may be grounds for denial of eligibility.*

*I understand and agree that to access DDDS Home and Community-Based or Institutional Services that can potentially be funded by Delaware Medicaid, I must:*

* *apply for, be approved for, and maintain eligibility for a Delaware Medicaid Program that covers Home and Community-Based Services.*
* *apply for all Social Security benefits to which I may be entitled, if I am seeking supports in a DDDS provider-managed residential setting, such as a group home, so that I can pay for my room and board costs.*

*DDDS will not use state funds for Home and Community-Based or Institutional Services that can be covered by Delaware Medicaid if the Applicant chooses not to enroll in the appropriate Delaware Medicaid program.*

**REQUIRED SIGNATURE (SELECT ONE)**

|  |  |
| --- | --- |
| Signature of Applicant, age 18 or older without a legal guardian | Date: |
| Signature of legal parent or guardian of applicant, under age 18 | Date: |
| Signature of legal guardian of applicant, age 18 or older | Date: |

**Applicant Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CONSENT FOR PROTECTED HEALTH INFORMATION TO DETERMINE ELIGIBILITY FOR DDDS SERVICES**

I, or my legal parent/guardian, hereby authorize the Division of Developmental Disabilities Services (DDDS) to disclose to the entities indicated below that I am applying for DDDS services, and to provide my Personal Health Information and/or any other documents requested on this consent for the purpose of determining my eligibility for DDDS services:

**\*Only check entities where you have received services**

|  |  |  |  |
| --- | --- | --- | --- |
| **ORGANIZATION** | **Check all that apply** | **ORGANIZATION** | **Check all that apply** |
| Child Development Watch |  | Nemours A.I. DuPont Hospital for Children |  |
| Delaware Psychiatric Center |  | Rockford Center |  |
| Division of Services for Children, Youth, and their Families |  | Social Security Administration/Disability Determination Services (DDS) |  |
| Division of Substance Abuse and Mental Health |  | SUN Behavioral Health |  |
| Division of Vocational Rehabilitation:  **Location:** |  | Other: Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Contact info.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Dover Behavioral Health System |  | Other: Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Contact info.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Meadow Wood Behavioral Health System |  | Other: Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Contact info.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Schools: Indicate last school attended (not to include college):  Current School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_\_\_\_\_  Former School:­­­ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_\_\_\_\_    Dates Attended: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |

**Requesting Agency** (to whom the information will be sent):

|  |  |  |
| --- | --- | --- |
| Division of Developmental Disabilities Services (DDDS), Office of Applicant Services | | |
| **Street Address:**  1052 South Governor’s Avenue, Suite 101 | | |
| **City:**  Dover | **State:**  DE | **Zip:**  19904 |

**Applicant Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SPECIFIC INFORMATION TO BE RELEASED:**

|  |  |  |  |
| --- | --- | --- | --- |
| **INFORMATION TYPE** | **Check all that apply** | **INFORMATION TYPE** | **Check all that apply** |
| Comprehensive Evaluation Reports |  | Evaluation Summary Reports |  |
| Individualized Education Program (IEP) reports |  | Psychoeducational Evaluations |  |
| Psychological Evaluations |  | Standardized Intellectual Functioning Assessments (IQ tests) |  |
| Standardized Adaptive Behavior Functioning Assessments |  | Comprehensive Evaluation with a standardized Assessment for Autism Spectrum Disorder (ASD) |  |
| Medical Records to confirm diagnosis |  | Other:(specify) |  |

The information requested includes assessments, medical evaluations, psychological testing, consultations, and discharge summaries. The dates of service to be covered by this authorization include all years of services received or admissions, or specific timeframes designated on the consent.

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

My signature indicates that I know what information is being disclosed and have had the chance to correct or change the information to make sure it is correct and complete. My signature also means that I have read this form, and/or had it read to me and explained in a language I can understand.

**REQUIRED SIGNATURE (SELECT ONE)**

|  |  |
| --- | --- |
| Signature of Applicant, age 18 or older without a legal guardian | Date: |
| Signature of legal parent or guardian of applicant, under age 18 | Date: |
| Signature of legal guardian of applicant, age 18 or older | Date: |

CONSENT FOR PROTECTED HEALTH INFORMATION TO DETERMINE ELIGIBILITY FOR DDDS SERVICES - Page 2

**Applicant Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**AUTHORIZATION TO ASSIST WITH DDDS APPLICATION FOR SERVICES**

Do you want to authorize anyone to assist you with the application process?  Yes  No

I hereby authorize the individual(s) named below to assist me in applying for DDDS services.

If additional information is needed after I submit the application, I authorize DDDS Applicant Services to include the person(s) assisting me on all correspondence related to the application process (e.g., letters detailing what information is needed, details of the eligibility determination, appeal process, etc.)

Individual authorized to assist me:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Information: Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_

**If you would like to authorize a second individual to assist, please complete section below:**

Individual authorized to assist me:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Information: Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_

**REQUIRED SIGNATURE (SELECT ONE)**

|  |  |
| --- | --- |
| Signature of Applicant, age 18 or older without a legal guardian | Date: |
| Signature of legal parent or guardian of applicant, under age 18 | Date: |
| Signature of legal guardian of applicant, age 18 or older | Date: |

**Applicant Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**FINANCIAL RESPONSIBILITY NOTICE**

THIS NOTICE DESCRIBES THE FINANCIAL RESPONSIBILITY OF THE APPLICANT OR PARENT OF A MINOR CHILD APPLYING FOR THE DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES (DDDS)

The applicant or parent of a minor child must demonstrate due diligence in taking all necessary steps for the applicant to become eligible for Medicaid and other benefits, such as those provided by the Social Security Administration. This may include the establishment of qualifying trusts that enable income and resources to be excluded from financial eligibility determinations for the purpose of establishing Medicaid eligibility.

Applicants seeking DDDS services who choose not to apply and/or maintain eligibility for Medicaid are legally responsible for the full cost of services. (29 Delaware Code, Section 7940).

Applicants seeking to receive institutional services at Stockley Center who choose not to apply and/or maintain eligibility for Medicaid are legally responsible for the full cost of services per 16 Delaware Code, Section 5520 for payment obligations.

The applicant is also responsible for any applicable premiums, co-pays, deductibles, and any other medical related expenses (i.e., medication, medical practitioner assessments, diagnostic tests, hospitalizations, etc.) not covered by health insurance.

**REQUIRED SIGNATURE (SELECT ONE)**

|  |  |
| --- | --- |
| Signature of Applicant, age 18 or older without a legal guardian | Date: |
| Signature of legal parent or guardian of applicant, under age 18 | Date: |

**Applicant Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ACKNOWLEDGEMENT OF HIPAA NOTICE OF PRIVACY PRACTICES**

**REQUIRED SIGNATURE (SELECT ONE)**

**My signature indicates that I have reviewed the attached HIPAA Notice of Privacy Practices.**

|  |  |
| --- | --- |
| Signature of Applicant, age 18 or older without a legal guardian | Date: |
| Signature of legal parent or guardian of applicant, under age 18 | Date: |
| Signature of legal guardian of applicant, age 18 or older | Date: |

If you have any questions, please do not hesitate to call us:

Phone: (302) 744-9700

TOLL FREE: (866) 552-5758, Option 2

FAX: (302) 744-9711

**HIPAA Notice of Privacy Practices**

**Revised Date: October 13, 2016**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION  
  
PLEASE REVIEW THIS DOCUMENT CAREFULLY**

**DDDS Responsibilities**

* The Delaware Division of Developmental Disabilities Services (DDDS) is a “covered entity” under HIPAA. As a covered entity, DDDS is required by law to maintain the privacy of your Protected Health Information (PHI), and to give you notice about our privacy practices, our legal duties, and your rights concerning your PHI. DDDS is also required to notify you of any breach of your unsecured PHI.

**HEALTH INFORMATION RIGHTS**

* **Right to Inspect and Copy**: With certain exceptions, you have the right to inspect or copy the PHI that we maintain on you. You must make a request in writing to obtain access to your PHI. Request must be made to: DDDS Health Information Management Department 26351 Patriots Way Georgetown, DE 19947. If you request copies, we may charge a reasonable, cost-based fee for staff time, postage, and printing cost.

* **Right to Amend**: you have the right to request that we amend the PHI that we maintain on you. We may deny your request to amend PHI if: (a) we did not create it and the originator remains available; (b) it is accurate and complete; (c) it is not part of the information that we maintain; or (d) it is not part of the information that you would be permitted to inspect or copy.
* **Right to Confidential Communications**: You have the right to request that we contact you in a specific way or send mail to a different address.
* **Right to Request Restrictions**: You have the right to request restrictions on how we use or disclose PHI.
* **Right to Disclosure Accounting**: You have the right to receive an accounting of the disclosures we have made of your PHI.
* **Breach Notification**: You have the right to be notified by us if there is a breach of your unsecured PHI.
* **Copy of Notice:** You have the right to receive a paper copy of this notice upon request.

**YOU DO NOT HAVE TO DO ANYTHING. THIS NOTICE IS JUST FOR YOUR INFORMATION.**

If you wish to inspect, copy, amend, make restrictions, or obtain your health information you must request it in writing to the: DDDS Health Information Management Department 26351 Patriots Way, Georgetown, DE 19947.

DDDS may use and disclose your protected health information without your authorization for treatment, payment and operational needs. We have listed the allowed uses and releases for which your authorization is not required below.

* **For Treatment**: We may share information about you to help you get health care. For example, we may tell your doctor about care you get in an emergency room.
* **For Payment**: We may use and share information so the care you get can be billed and paid for. For example, we may ask an emergency room before we pay the bill for your care.
* **For Business Operations**: We may need to use and share information for our business operations. For example, we may use information to review the quality of the care you get.
* **Exceptions**. For certain kinds of records, your permission may be needed even for release for treatment, payment, or business operations.
* **As Required by Law.** We will share information when we are required by law to do so. Examples of such release would be law enforcement or in response to a court order or subpoena. We may also share information to prevent a serious threat to health, safety or other emergencies. We may also share information to allow government agencies to review our activities.
* **With your Permission**. If you give us permission in writing, we may use and share your information. If you give us permission, you have the right to change your mind and take it back. This must be in writing too. We cannot take back any uses already made with your permission.

DDDS has the right to change this notice. A changed notice will be for information we already have as well as information we get in the future. We must follow whatever notice is currently in effect. We will send a new notice to you if the change we make is important. We will also post a copy of the current notice on our website at <https://dhss.delaware.gov/dhss/ddds/>

If you believe your privacy rights have been violated, you may file a complaint by writing to:

Stockley Center

Attention: HIPAA Privacy/Complaints Officer

26351 Patriots Way

Georgetown, DE 19947

**Or**:

Region III, Office for Civil Rights, U.S. Department of Health and Human Services

150 S. Independence Mall West, Suite 372, Public Ledger Building

Philadelphia, PA 19106-3499

Main Line (215) 861-4441  
Hotline (800) 368-1019

**You will not be penalized for filing a complaint with the federal government.**