DELAWARE HEALTH AND SOCIAL SERVICES
Division of Developmental Disabilities Services

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: (MM/DD/YYYY)	Age:	Social Security #:
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)

☐ American Indian/Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian/Pacific Islander
☐ White
☐ Other
☐ Unknown/Declined

Ethnicity

☐ Hispanic or Latino
☐ Non-Hispanic or Latino
☐ Unknown/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:

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.