DELAWARE HEALTH AND SOCIAL SERVICES
Division of Developmental Disabilities Services

INSTRUCTIONS FOR THE DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES (DDDS) APPLICATION TO DETERMINE ELIGIBILITY

The Division of Developmental Disabilities Services supports individuals with intellectual and developmental disabilities, Autism and Prader Willi Syndrome. Individuals may apply to become eligible for services from the Division of Developmental Disabilities Services (DDDS) for yourself, for your child or for someone for whom you have guardianship.

How do I apply?

Please complete and submit the Application For Services and supporting documents. The application gathers information from you that will enable DDDS to determine whether you meet the eligibility criteria established in section 2100 of Title 16 of the Delaware Administrative Code.

What types of assessments are required with the application?

DDDS requires documentation to establish that the applicant has one of the qualifying conditions (intellectual and developmental disability, Autism or Prader Willi Syndrome) and, where applicable, that the applicant also meets the threshold for the functional level.

Documentation of intellectual and developmental disability may include diagnostic assessments completed by school or private licensed practitioners, or, in some cases, medical records completed by qualified practitioners prior to the applicant's 22nd birthday. It is best to submit copies of educational, psychological, and adaptive functioning assessments with a complete application, as it streamlines the application review process. Documentation may be submitted separately, however, DDDS may need to request additional or more current assessments or medical records in order to determine eligibility.

The types of assessments most frequently used to determine eligibility are as follows:

Standardized Intellectual Functioning Assessment (Wechsler Intelligence Scales, Stanford-Binet Intelligence Scale)	Adaptive Behavior Functioning Assessment (Vineland Adaptive Behavior Scale, Adaptive Behavior Assessment System)
Standardized Assessment for Autism Spectrum Disorder by a Licensed Practitioner	Copy of physician report diagnosing Prader Willi or Brain Injury

A complete list of the DDDS accepted assessment instruments is available at the following link: https://dhss.delaware.gov/dhss/ddds/files/assessmentslist2020.pdf

What other documents are needed?

In addition to the application and assessments required, all applicants must submit copies of the following documents:

- Birth Certificate
- Social Security Card
- Documentation of alien status for non-citizens of the United States of America
- Medicaid card (if applicable)
- Proof of Delaware Residence (i.e. State issued DE ID Card, current Individual Education Plan -IEP, etc.)
- Guardianship order by DE Family Court for minors or the Court of Chancery for adults,if applicable

The applicant must also sign the following documents at the time of application if age 18 or older:

- Application
- Consent for Health Information to Determine Eligibility
- Financial Responsibility Notice
- HIPAA Notice of Privacy Practices

Please note that if the applicant has a DE legal guardian, then, the guardian must sign the required documents. If documentation of a DE guardianship order is not submitted, then the applicant must sign the application. If the applicant cannot sign, he/she must make a mark on the signature line (signature by mark) and have it witnessed by an adult.

Where do I submit an application for eligibility?

You may mail it to:

Office of Applicant Services
Division of Developmental Disabilities Services
Woodbrook Professional Center
1052 South Governor's Avenue, Suite 101
Dover DE 19904

or:

You may fax it to: (302) 744-9711

What happens after the application is received?

Once the DDDS Office of Applicant Services receives an application, it sends a letter to the applicant confirming receipt which includes information on the next steps. DDDS will determine eligibility within 30 days of receiving the complete application with all required reports and assessments. DDDS will send a letter to the address on the application indicating its determination. If DDDS determines that the applicant does not meet the eligibility criteria, the letter will indicate the basis for the determination.

If DDDS cannot determine eligibility based on the information included with the application, an Applicant Services Coordinator (ASC) will contact the applicant via written correspondence within 30 days to request specific additional information. If needed, the Coordinator can make recommendations for options and sources to obtain the required information. DDDS will not be able to make an eligibility determination if you do not submit a complete application and all required documents.

What do I do if I need help with the application process?

If you need help or have any questions about the application process, please do not hesitate to call the DDDS Office of Applicant Services: (302) 744-9700 or Toll Free at 1-866-552-5758, Option 2. Fax: (302) 744-9711.

If I do not meet eligibility criteria, is there an appeal process?

Yes. If you disagree with the eligibility determination, you have a right to appeal the decision. You will receive written information on the options to appeal the decision with the eligibility determination letter. If you require additional information, you may contact the Appeal Committee Chairperson at (302) 744-9628.

APPLICATION FOR SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES (DDDS)

APPLICANT CONTACT INFORMATION

Name:
Address:
Phone Number: (Indicate cell, home or work): ☐ Cell ☐ Home ☐ Work
Alternate Phone Number: (Indicate cell, home or work): ☐ Cell ☐ Home ☐ Work
Email Address:
Delaware Medicaid # (if applicable): Social Security #:
** *Attach copy of Birth Certificate, Social Security Card, and Medicaid Card (if applicable)***
Gender (Male/Female): ☐ Male ☐ Female Date of Birth (MM/DD/YYYY):

Primary Race/Ethnicity of Applicant:
- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian/Pacific Islander
- ☐ White
- ☐ Other
- ☐ Hispanic
- ☐ Unknown

Secondary Race/Ethnicity of Applicant:
- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian/Pacific Islander
- ☐ White
- ☐ Other
- ☐ Hispanic
- ☐ Unknown

Primary Language of Applicant:

Primary Language of Family (if different than Applicant):

Interpreter Services Needed (if we need to contact you)? ☐ Yes ☐ No

DIAGNOSTIC INFORMATION NECESSARY TO DETERMINE ELIGIBILITY

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

1. Have you been diagnosed with any of the following?

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 that verifies the above. The standardized testing or assessment must have been completed prior to age 22 to be used to determine eligibility.

2. Has a standardized assessment of adaptive behavior been administered for the applicant that asks about how well the applicant can do things on his/her own or with help from others such as personal care (bathing, washing your hair, etc.), cooking, cleaning, or using public transportation?
   ☐ Yes ☐ No

   If yes, please provide a copy of the standardized assessment. The assessment must have been completed prior to age 22 to be used to determine eligibility.

Standardized instruments, assessments or evaluations used/accepted by DDDS to determine eligibility are listed on the DDDS website at: https://dhss.delaware.gov/dhss/ddds/files/assessmentslist2020.pdf
You can also request a copy from Applicant Services by calling 302-744-9700.

Is someone appointed as applicant's guardian of: ☐ Person ☐ Property ☐ Both

If yes, please provide that person's name and contact information below and attach a copy of the guardianship order with this application.

PARENT OR GUARDIAN CONTACT INFORMATION (if applicable)

Name:

Mailing Address:

Phone Number: (Indicate cell, home or work): ☐ Cell ☐ Home ☐ Work

Alternate Phone Number: (Indicate cell, home or work): ☐ Cell ☐ Home ☐ Work

Relationship to Applicant: ☐ Parent ☐ Guardian ☐ Both

E-mail Address:

If applicant does not have a guardian, does the applicant have a substitute decision maker who can help with making decisions? ☐ Yes ☐ No

If yes, what is that person's name and contact information?

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
(If a lawful alien, you must provide documentation of your lawful status.)

Is applicant a resident of the State of Delaware? ☐ Yes ☐ No

Possible 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
- Copy of lease at location occupied by applicant
- Copy of current Individual Education Plan (IEP) with a Delaware address from a state of Delaware school, etc.

APPLICATION FOR SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES (DDDS)

ADDITIONAL QUESTIONS

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 I have provided true and complete answers to the questions to the best of my knowledge. 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 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.

Person helping applicant complete this application (if applicable):

Name: Phone: Email:

Required Signatures:

Signature of Applicant:

Print Applicant Name	Applicant Signature	Date

Relationship of alternate signatory (parent or guardian) to Applicant:

If signature is a mark (X), then a witness is required:

Print Witness Name	Witness Signature	Date

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Developmental Disabilities Services

Applicant Name: _____

Date of Birth: _____

CONSENT FOR PROTECTED HEALTH INFORMATION TO DETERMINE ELIGIBILITY FOR DDDS SERVICES

I, or my authorized representative, hereby authorizes the Division of Developmental Disabilities Services (DDDS) to disclose to the entities below that I am applying for DDDS services and to obtain my Personal Health Information and/or any other documents requested on this consent from the following entities for the purpose of determining my eligibility for DDDS services:

ORGANIZATION	YES	ORGANIZATION	YES
Child Development Watch	☐	Nemours A.I. DuPont Hospital for Children	☐
Delaware Psychiatric Center	☐	Rockford Center	☐
Division of Prevention and Behavioral Health Services	☐	Social Security Administration/Disability Determination Services (DDS)	☐
Division of Substance Abuse and Mental Health	☐	SUN Behavioral Health	☐
Division of Vocational Rehabilitation: Location:	☐	Other (specify):	☐
Dover Behavioral Health System	☐	Other (specify):	☐
MeadoWood Behavioral Health System	☐	Other (specify):	☐

Schools: List last school attended (not to include college):

☐ Current Student _____

☐ Former Student _____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

Specific Information to be Released: (Please 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)

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Developmental Disabilities Services

Applicant Name: _____

Date of Birth: _____

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 by the Applicant.

This authorization is valid for one (1) year from the date signed, and, I understand that I may revoke this authorization 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. I am aware that this consent can be revoked in writing at any time. 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. All blank spaces have been filled in except for signatures and dates.

Required Signatures:

Signature of Applicant: _____ _____
Signature Date

If signature is a mark (X), then a witness is required:

Name and signature of witness, where applicable:

_____ _____ _____
Print Name Signature Date

Relationship of Witness to Applicant:

_____

Name and signature of guardian or parent for minors, where applicable:

_____ _____ _____
Print Name Signature Date

Relationship of other signer to Applicant:

_____

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Developmental Disabilities Services

Authorization to Assist with DDDS Application for Services

Applicant Name: _____ Date of Birth: _____
(print)

I hereby authorize the individual named below to assist me to apply for DDDS services.

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

The person authorized to assist me is:

Name: _____ Relationship: _____

Contact Information: Phone: _____

E-mail: _____

Address: _____

Signature of Applicant: _____ _____
Signature Date

If signature is a mark (X), then a witness is required:

Name and signature of witness, where applicable:

_____ _____ _____
Print Name Signature Date

Relationship of Witness to Applicant: _____

Name and signature of guardian or parent for minors, where applicable:

_____ _____ _____
Print Name Signature Date

Relationship to Applicant: _____

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Developmental Disabilities Services

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 become eligible for Medicaid are legally responsible for the full cost of services. (29 Delaware Code, Section 7940). https://delcode.delaware.gov/title29/c079/sc03/index.shtml

Applicants seeking to receive institutional services at Stockley Center who choose not to become eligible for Medicaid are legally responsible for the full cost of services per 16 Delaware Code, Section 5520 for payment obligations. https://delcode.delaware.gov/title16/c055/sc02/index.shtml

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

Required Signatures:

Signature of individual applying for services: _____ _____
Signature Date

If signature is a mark (X), then a witness is required:

Name and signature of witness, where applicable:

_____ _____ _____
Print Name Signature Date

Relationship to Applicant: _____

Name and signature of parent for minors, where applicable:

_____ _____ _____
Print Name Signature Date

Relationship to Applicant: _____

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Developmental Disabilities Services

Acknowledgement of HIPAA Notice of Privacy Practices

Applicant Name: _____ Date of Birth: _____

My signature indicates that I have reviewed the DDDS HIPAA Notice of Privacy Practices

_____ _____
Signature Date

If signature is a mark (X), then a witness is required:

Name and signature of witness, where applicable:

_____ _____ _____
Print Name Signature Date

Relationship of Witness to Applicant: _____

Name and signature of guardian or parent for minors, where applicable:

_____ _____ _____
Print Name Signature Date

Relationship to Applicant: _____

Please forward this signed Acknowledgement of the HIPAA Notice of Privacy Practices with the completed application and release of information form to:

Office of Applicant Services
Division of Developmental Disabilities Services
Woodbrook Professional Center
1052 South Governor's Avenue, Suite 101
Dover, DE 19904

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

DELAWARE HEALTH AND SOCIAL SERVICES

Division of Developmental Disabilities Services

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 IT 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 http://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

Si necesita esta noticia en Espanol favor de llamar 1-800-372-2022