ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

APPLICATION FOR ELIGIBILITY DETERMINATION

HOW TO APPLY:

STEP 1) Complete the DDD Eligibility Checklist (DDD-1991A) for a **complete packet** guide

STEP 2) Complete and hand-sign pages 2, 3 & 4 of this application (DDD-1972A)

STEP 3) Gather documents that support one of the five qualifying diagnoses and substantial limitations (see DDD-0640A):

- ☐ Copy of U.S. birth certificate OR citizenship / immigration *(ex: refugee, legal status, etc.)*
- ☐ Written proof of Arizona residency showing the applicant's name and residential address *(ex: applicant's Arizona driver's license, Arizona identification card or Arizona motor vehicle registration; utility bill, lease, mortgage or rent receipt; certified copy of a school record; or signed employment statement from applicant's non-relative employer)*
- ☐ Guardianship / Legal responsibility documents *(if applicable)*
- ☐ Copy of all medical insurance cards *(front / back)*
- ☐ Diagnosis evaluation / School report showing proof of the lifelong condition. ***Check all that apply:***
  - ☐ Autism Spectrum Disorder ☐ Cerebral Palsy ☐ Intellectual (cognitive) Disability ☐ Epilepsy
  - ☐ At Risk for one of them (if under the age of 6 only) ☐ Down Syndrome

STEP 4) After reviewing the previous steps and what is required, are you ready to apply now? ☐ Yes ☐ No

If **NO**, please apply when you have a **complete packet** or call 1-844-770-9500 to speak with a DDD Eligibility Specialist. If **YES**, continue to submit your application and supporting documents by **1)** email to DDDAPPLY@azdes.gov; **2)** Walk-in drop off and have the office send the completed application to DDDAPPLY@azdes.gov.

Flagstaff	**Chandler**	**Phoenix** (Central)	**Phoenix** (West)	**Tucson**
DDDAPPLY@azdes.gov	DDDAPPLY@azdes.gov	DDDAPPLY@azdes.gov	DDDAPPLY@azdes.gov	DDDAPPLY@azdes.gov

SECTION A. (Applicant Information)

Name: _____ Date of Birth: _____ Sex: ☐ Male ☐ Female

AHCCCS A Number *(If applicable)*: _____ Primary Language: _____

Home Address *(No., Street)*: _____

City: _____ State: _____ ZIP Code: _____ Phone: _____

Ethnicity: _____ Tribe *(If applicable)*: _____

Mailing Address *(If applicable)*: _____

City: _____ State: _____ ZIP Code: _____

Contact Preference: ☐ Phone ☐ Email: _____

Do you want to register to vote? ☐ Yes ☐ No

SECTION A.1

Professionals who can provide records for all qualifying disabilities:

- Licensed psychologist
- School psychologist
- Psychiatrist
- Pediatrician
- Neurologist
- Early intervention team
- Neonatologist
- Certified Geneticist
- Licensed Primary Care Physician

Professionals accepted vary by disability. Ask your eligibility specialist if you have questions.

Names and Contact Information	Type of Professional	Date of Evaluation

See page 3 for EOE/ADA/LEP/GINA disclosures

SECTION B. (Parent/Foster parent, if applicable)

Name: _____ Relationship: _____

Phone: _____ Email: _____

Address *(If different than applicant)*: _____ Alt: _____

City: _____ State: _____ ZIP Code: _____ Best way to contact you: _____

Legal Guardian Name *(If different than above)*: _____

Relationship: _____ Phone: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

(Legal guardian is a person who is appointed by a judge.)

SECTION C. Health Insurance

Type of Coverage *(private, public, etc.)*	Name of Health Plan	Policy Holder Name	ID/Group # and Policy #	Effective Date	Policy Holder's Date of Birth

SECTION D. (Early Intervention and Educational History, if Applicable)

Early Intervention Program State or School Name and School District	Type of Support *(Services or type of plan such as Individual Education Plan or 504 Plan)*	Dates Attended

By signing below, I agree that:

- I am applying as a or for the person named above who is a resident of the State of Arizona.
- I have been informed of the services provided by this agency.
- I understand that if I am referred to AHCCCS for an ALTCS eligibility determination, I must cooperate in this determination process.
- As part of my application to this division, I have been informed of the DDD eligibility criteria and of my rights relevant to the application process.
- Applicants are required to assign rights to insurance benefits in accordance with R6-6-1303. If I am eligible and assigned to services, I authorize the release of information necessary to file a claim to my insurance company.
- I attest that everything I have stated in this application is true.

Who can sign the application?

- An applicant over 18 years of age without a court appointed legal guardian
- A biological or adoptive parent applying for a minor child *(including children in foster care where parental rights have not been terminated)*
- A Child Safety Specialist from the Department of Child Safety, for children in foster care if the biological/adoptive is unavailable *(must have documentation showing reasonable efforts to obtain biological/adoptive parent signature)*
- A legal guardian, appointed by a court *(need to have documents of guardianship)*

Name *(Please print)*: _____

Relationship to Applicant *(i.e. parent, court appointed guardian, self)*: _____

Responsible Person's Signature: _____ Date: _____
(Hand signed signature required)

Equal Opportunity Employer / Program • Auxiliary aids and services are available upon request to individuals with disabilities • To request this document in alternative format or for further information about this policy, contact the Division of Developmental Disabilities Customer Service Center at 1-844-770-9500; TTY/TDD Services: 7-1-1 • Disponible en español en línea o en la oficina local

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Health Insurance Portability and Accountability Act (HIPAA) Act of 1996 45 C.F.R. 164.508

Name of Individual/Client whose health information will be shared *(Last, First, Middle)*:

_____ Date of Birth: _____

Describe what this information will be used for and why it is needed:

I authorize **Arizona Department of Economic Security, Division of Developmental Disabilities (DDD)** to disclose (share) protected health information described above to the individual/agency below.

Individual/Agency requesting or needing information:

_____ Date of Request: _____

By signing this Authorization, I understand that:

I understand that once the records and information authorized herein are disclosed to entities or persons outside of DDD, they could be redisclosed by the recipient(s) and may no longer be protected by the Health Insurance Portability and Accountability Act of 1996. However, DES/DDD service providers generally are bound by contract and law to maintain the confidentiality of the health and other information received, especially that relating to HIV infection, AIDS or AIDS-related conditions, and psychological or psychiatric conditions.

I do not have to sign this authorization. I understand that a health care provider or health plan may not condition treatment, payment, enrollment or eligibility in a health plan or eligibility for health care benefits on my signing this authorization except as provided under state or federal law.

- I may have a copy of this document.
- I may revoke this authorization at any time, by sending written notification of the revocation; except to the extent that the disclosed authorization has been acted upon.
- A copy of this authorization shall be as valid as the original.
- Copy fees will not be reimbursed by the Division.
- This authorization shall expire a year from the date below.

Printed Name of Parent or Legal Guardian: _____

Signature of Parent or Legal Guardian: _____ Date of Authorization: _____

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

AUTHORIZATION FOR RELEASE OF INFORMATION

Individual's Full Name: _____ Date of Birth: _____
(Last, First, Middle)

I give permission for the following entity to share my protected health information:

Medical Professional/Agency/Educational Setting/Other:

_____ Date of Request: _____

To the Division of Developmental Disabilities:

Address *(No., Street)*: _____

City: _____ State: _____ ZIP Code: _____

Phone Number: _____ Fax Number *(If faxing)*: _____

I allow the protected health information checked below to be shared with the medical professional, agency, educational setting or other listed above:

- ☐ Physician Records
- ☐ Newborn Records
- ☐ Labor, Birth & Delivery Records
- ☐ Audiology Records/Reports
- ☐ Psychological Reports
- ☐ Occupational Therapy Reports
- ☐ Speech and Language Reports
- ☐ Physical Therapy Reports
- ☐ Mental Health Records
- ☐ Latest 504 Plan or Individual Education Plan and Evaluation Report
- ☐ Other *(Specify)*: _____

This disclosure is being made at my request, and I choose not to state the reason for this disclosure. Information will be used to determine eligibility for the Division of Developmental Disabilities. This authorization shall expire a year from the date below.

I understand that once the records and information authorized herein are disclosed to entities or persons outside of DDD, they could be redisclosed by the recipient(s) and may no longer be protected by the Health Insurance Portability and Accountability Act of 1996. However, DES/DDD service providers generally are bound by contract and law to maintain the confidentiality of the health and other information received, especially that relating to HIV infection, AIDS or AIDS-related conditions, and psychological or psychiatric conditions.

By signing this **Authorization**, I understand that:

- I may refuse to sign this authorization; however, I understand that the DDD may not be able to determine eligible for services.
- I may inspect or copy any information to be disclosed under this authorization.
- I may have a copy of this document.
- I may revoke this authorization at any time, by sending written notification of the revocation; except to the extent that the disclosed authorization has been acted upon.
- A copy of this authorization shall be as valid as the original.
- Copy fees will not be reimbursed by the Division.

Printed Name of Parent or Legal Guardian: _____

Signature of Parent or Legal Guardian: _____ Date of Authorization: _____