ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

DDD ELIGIBILITY PACKET

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DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

How DDD Eligibility is Determined

A. Age 0 (birth) to 3:

For early intervention services, children age birth to three must have a significant delay in one or more developmental areas or an established condition that could lead to a developmental disability. To make a referral for a child, please contact the AzEIP Central Referral Line (Raising Special Kids) toll-free at (800)237-3007 or by e-mail at AzEIP.Info@raisingspecialkids.org. Once a child has been made eligible for AzEIP, with the family's consent, DDD eligibility will be determined.

B. Age 3 to 6:

A person age 3 years to 6 years must **1)** voluntarily apply, **2)** be an Arizona resident, and **3)** either have one of the following developmental disabilities: Autism Spectrum Disorder, Cerebral Palsy, Intellectual (Cognitive) Disability, Epilepsy, Down Syndrome OR be at-risk for developing one of these disabilities to qualify for Division of Developmental Disabilities services.

Question	Requirements
How do I know?	A developmental assessment, provided by a medical professional or school evaluator trained in childhood development, can be used to identify a developmental delay that could lead to a developmental disability.
Who can provide the information to me?	Professionals trained in early childhood development include: • Licensed Physician, such as a Family Physician or Neonatologist • School Psychologist • Early Childhood Education Specialist • Physician's Assistant • Clinical Geneticist • Pediatrician including Developmental Pediatrician • Licensed Psychologist • Nurse Practitioner • Neurologist
Are there other disabilities accepted?	Yes: Spina Bifida with Arnold Chiari Malformation, Periventricular Leukomalacia, Chromosomal Abnormalities with high risk for Intellectual Disability, Post-Natal Traumatic Brain Injury (such as Shaken Baby Syndrome or near drowning), Hydrocephaly, Microcephaly, disorders due to drug or alcohol (such as Fetal Alcohol Syndrome), and birth weight under 1000 grams with neurological impairment.

C. Age 6 to Adult:

A person must **1)** voluntarily apply, **2)** be an Arizona resident, and **3)** be diagnosed with a developmental disability (listed below) which developed before the age of 18 and is likely to continue indefinitely, and **4)** there must also be significant limitations in daily life skills related to the disability (see next page).

Diagnosis	Requirements
CEREBRAL PALSY	The evaluation report must include a description of how the practitioner came to the decision regarding the diagnosis. *DDD accepts evaluations by a licensed physician.*
EPILEPSY	The evaluation report must include a description of how the practitioner came to the decision regarding the diagnosis. *DDD accepts evaluations by a licensed physician.*
AUTISM SPECTRUM DISORDER	The evaluation report must include a description of how the practitioner came to the decision regarding the diagnosis. *DDD accepts evaluations by a Psychiatrist, Licensed Psychologist, Child Neurologist, Developmental Pediatrician and Pediatricians with specialized training in Autism.*
INTELLECTUAL (COGNITIVE) DISABILITY	The evaluation report must include standardized intellectual testing (IQ) and adaptive behavior testing that leads to the diagnosis or Special Education category of Intellectual Disability. The Individual Education Plan (IEP) and Multidisciplinary Evaluation Team report (MET) can be used together. *DDD accepts evaluations by a licensed psychologist, certified school psychologist or psychometrist working under a licensed psychologist or certified school psychologist.*
DOWN SYNDROME	A Licensed Primary Care Physician, Developmental Pediatrician, Neonatologist, or Clinical Geneticist shall diagnose Down Syndrome. The physician shall submit the diagnostic prenatal or postnatal genetic testing results and a report to the Department documenting how the practitioner came to the diagnosis based on the diagnostic prenatal or postnatal genetic testing.

Substantial Functional Limitations:

In addition to being diagnosed with at least one developmental disability, the person must show significant limitations in daily life skills due to their qualifying diagnosis in three **(3)** of the following. *(Note: The age of the person is taken in to consideration when identifying significant limitations in daily life skills.)*

RECEPTIVE AND EXPRESSIVE LANGUAGE

- Cannot communicate with others
- Cannot communicate effectively without the assistance of others or a mechanical device

LEARNING

- Cannot participate in age appropriate learning without assistance

SELF-DIRECTION

- Needs assistance with making decisions that affect their well being
- Does not have safety awareness skills
- Needs help with personal finances

SELF-CARE

- Needs significant help with bathing, toileting, tooth brushing, dressing and grooming (taking care of themselves)
- The time to complete self-care activities takes so long it affects attendance or success in school, employment or other activities of daily living

MOBILITY

- Fine and motor skills are impaired
- Needs assistance from a mechanical device like a wheelchair or a walker to move from place to place
- The time it takes for the person to move takes so long that it affects keeping a job or completing activities of daily living

CAPACITY FOR INDEPENDENT LIVING

- Needs daily supervision to help with health and safety
- This includes completing household chores, preparing simple meals, using microwaves or other household equipment, using public transportation and shopping for food and clothing

ECONOMIC SELF-SUFFICIENCY

- Can't perform tasks to keep a job
- Is limited in what they can earn
- Considering all expenses and the disability, the person earns below federal poverty level

For Questions Call Toll Free 1-844-770-9500 or E-mail DDDApply@azdes.gov

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
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DDD ELIGIBILITY CHECKLIST

What is a complete packet?

What do I need?	What is it?	Why do I need it?	Do I have it?
Hand signed Application for Eligibility Determination (DDD-1972A)	Four-page document that asks for information about you and your child or the person you are applying for. It allows us to work with other people or agencies to help you.	DDD needs information about you or your child in order to decide if you or your child is eligible.	☐ Yes ☐ No
Copy of birth certificate (or citizenship / immigration document)	Documentation demonstrating citizenship or lawful presence in the United States.	The State of Arizona requires that DDD help people who are born in the United States or have legal residency in the United States. There are other documents you can show us to meet this requirement. Ask your eligibility specialist if you need another option.	☐ Yes ☐ No
Proof of Arizona residency (lease, utility bill, State ID/Driver License)	Documentation showing the applicant's name and current residential address.	The state of Arizona requires all recipients to be residents of Arizona at the time of the application.	☐ Yes ☐ No
Health Coverage, copy of front / back (if applicable)	A card or document given to you when you have health insurance coverage by the state or a private insurance company.	Your insurance company may have the responsibility to pay for medical costs before DDD pays for some or all the cost.	☐ Yes ☐ No
Records showing a qualifying disability	Documents by a school and / or doctor that show you or your child has a disability. (See DDD-0640A "How DDD Eligibility is Determined" flyer for information based on age and disability).	DDD needs to know if your child or the person you are applying for has a qualifying disability. • Cerebral Palsy • Epilepsy • Autism Spectrum Disorder • Intellectual (Cognitive) Disability • Down Syndrome At Risk for one of the above (under age 6 only).	☐ Yes ☐ No
School Evaluation Documents (if applicable)	A report showing observations and tests that helps decide if your child needs help at school. A document that shows how the school will meet your child's needs. (Individual Education Plan (IEP) and Multidisciplinary Evaluation Team (MET) or Psychoeducational report).	It helps us determine if your child meets DDD eligibility requirements.	☐ Yes ☐ No
Documents Showing Legal Responsibility / Guardianship (if applicable)	Court-issued or legal document showing who has the right to make legal decisions.	DDD needs to know who has the right to make legal decisions about your child or the person applying.	☐ Yes ☐ No

If you have any questions, please call our DDD Customer Service Center at 1-844-770-9500 or email your question to DDDApply@azdes.gov.

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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
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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: _____

How do I find out if I qualify for the Division of Developmental Disabilities?

DEPARTMENT OF ECONOMIC SECURITY
Your Partner For A Stronger Arizona

APPLICATION REQUIREMENTS AGE 3 TO ADULT

- Complete, signed application
- Applicant must be Arizona resident
- Documentation showing legal status
- Copy of medical insurance (if applicable)
- Copy of diagnosis evaluation/report
- Individual Education Plan (IEP) and Multidisciplinary Evaluation Team (MET) or Psychoeducational school report.

***For "Birth Until Age 3" See AzEIP**

BIRTH UNTIL AGE 3

*AzEIP

- Arizona Early Intervention Program
- Contact Raising Special Kids
- Phone: (800) 237-3007
- Complete Referral at des.az.gov/azeipref

AGE 3 UNTIL AGE 6

QUALIFYING DIAGNOSIS

- Cerebral Palsy
- Epilepsy
- Intellectual (cognitive) Disability
- Autism Spectrum Disorder
- Down Syndrome
- Or be at risk of developing one of these disabilities
- Exhibit "significant delay" in one or more areas that could lead to a developmental disability

AGE 6 TO ADULT

QUALIFYING DIAGNOSIS

- Cerebral Palsy
- Epilepsy
- Intellectual (cognitive) Disability
- Autism Spectrum Disorder
- Down Syndrome

Must have one or more of the qualifying diagnoses and provide documentation that the disability started before the age of 18.

+

SUBSTANTIAL FUNCTIONAL LIMITATIONS (SFL)

Receptive and Expressive Language

Learning

Self-Direction

Self-Care

Mobility

Economic Self-Sufficiency

Capacity for Independent Living

Qualifying applicants must have 3 or more SFL due to the qualifying diagnosis

Member eligibility is "re-determined" at ages six (6) and eighteen (18) to verify the member is eligible and in need of DDD services.

FOR MORE INFORMATION PLEASE CALL 1 (844) 770-9500 OPTION 4
OR EMAIL DDDAPPLY@AZDES.GOV

DDD-1954A POSENG (10-22)