



AGE OF 6 REDETERMINATION PACKET INFORMATION

What does redetermination mean?

“Redetermination” means the Division of Developmental Disabilities (DDD) looks at the information we have about your child. DDD will review it and decide if your child is still eligible for DDD. Your child will continue to receive support and services during the redetermination process. DDD will tell you if your child is not eligible. DDD will also tell you what to do if you disagree.

What will happen during redetermination?

- You will not need to fill out a new application for DDD eligibility.
- DDD will review your child’s records **90** days before their **6th** birthday.
- DDD will verify your child’s records show a DDD-qualifying diagnosis and at least three (3) substantial functional limitations.
- DDD will not ask for more information if it has ALL the records needed.
- Once a decision is made, DDD will contact you by phone, email, or letter to let you know the results.

How is my child eligible?

Your child must have:

At least one (1) of five (5) qualifying diagnoses:

- Autism;
- Cognitive/Intellectual Disability;
- Epilepsy;
- Cerebral Palsy; or
- Down Syndrome, and

At least three (3) of seven (7) substantial functional limitations because of the qualifying diagnosis.

What are the qualifying substantial functional limitations?

The substantial functional limitations are Learning, Self-Direction, Self-Care, Receptive and Expressive Language, Mobility, Capacity for Independent Living, and Economic Self-Sufficiency.



What can I do to help during redetermination?

Give your Support Coordinator any new:

- Medical, behavioral, and/or psychological records and evaluations.
- Multidisciplinary Evaluation Team (MET) and Individualized Education Plan (IEP) records.
- Physical, speech, or occupational therapy records.

Where do I send the new records?

Send your new records to your assigned Support Coordinator at any time by fax, email, or mail. You can also give a copy to your SC at your next Person-Centered Service Plan meeting.

What if I need help?

DDD can help you get records. Sign the Release of Information form (at the end of this packet) with the names of the places you need us to ask for records. You must sign a Release of Information form for each place you need us to request records.

What if my child does not have a DDD qualifying diagnosis?

Discuss your child’s needs with your DDD Support Coordinator, and they can discuss options and community resources.

What if my child is found not eligible?

DDD will write you a letter and tell you why if your child is found ineligible. The letter will tell you how to file an [Administrative Review](#) if you disagree with the decision. Your family member will continue to get all their services and support during this process.

Will my child lose insurance?

No, as long as your child continues to meet the AHCCCS eligibility requirements. Be sure to reach out to Arizona Long Term Care Services 602-417-6600 for further ALTCS and AHCCCS eligibility requirements.

Have questions?

Email any questions to DDDredeterminations@azdes.gov

DDD Age of 6 Redetermination Checklist

Please provide all “checked marked” documents to your Support Coordinator

Do you have one of the following DDD qualifying disabilities?	Acceptable DDD providers who can administer diagnosis (1 only per diagnosis)	Type of evaluation needed (1 only per diagnosis)	If your child does receive educational services, DDD needs:
Autism	-Developmental Pediatrician -Licensed Psychologist -Psychiatrist -Neurologist -Pediatrician who completed specialized training approved by the Division Yes No	-Psychological -Psychiatric -Neurological evaluation -Developmental -Medical Yes No	Their most recent Multidisciplinary Evaluation Team (MET) and Individual Education Plan (IEP) or 504 plan. Yes No
Cognitive/ Intellectual Disability	-Licensed Psychologist or -School Psychologist Yes No	-Psychological evaluation with both IQ and adaptive testing Yes No	Their most recent Multidisciplinary Evaluation Team (MET) and Individual Education Plan (IEP) Yes No
Epilepsy	-Primary Care Physician (PCP) -Neurologist -Orthopedist Yes No	-Medical -Orthopedic -Neurological evaluation Yes No	Their most recent Multidisciplinary Evaluation Team (MET) and Individual Education Plan (IEP) or 504 plan Yes No
Cerebral Palsy	-Primary Care Physician (PCP) or -Neurologist Yes No	-Medical -Orthopedic -Neurological evaluation Yes No	Their most recent Multidisciplinary Evaluation Team (MET) and Individual Education Plan (IEP) or 504 plan Yes No
Down Syndrome	-Primary Care Physician (PCP) -Developmental Pediatrician -Neonatologist -Clinical geneticists Yes No	-Medical evaluation containing genetic testing Yes No	Their most recent Multidisciplinary Evaluation Team (MET) and Individual Education Plan (IEP) or 504 plan Yes No

Complete a DDD-1972A “Authorization for Disclosure of Protected Health Information” form for each provider if you need help getting records from your child’s school or doctor’s office and give them to your Support Coordinator.

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 ADA Coordinator at 602-771-2893; TTY/TDD Services: 7-1-1 • Disponible en español en línea o en la oficina local.

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DDD-1972A FORFF (12-20)
DDD-2249A Packet

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: _____

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