



DIVISION OF DEVELOPMENTAL DISABILITIES (DDD)  
**REQUEST FOR DDD  
ELIGIBILITY DETERMINATION**

**FOR OFFICE USE ONLY**

Initial       Reapplication  
DDD NUMBER:

**Applicant Information**

<b>LAST NAME</b>		<b>FIRST NAME</b>		<b>MIDDLE NAME/INITIAL</b>		<b>BIRTHDATE</b>		<b>SOCIAL SECURITY NUMBER</b>			
<b>ADDRESS</b>					<b>CITY</b>		<b>STATE</b>		<b>ZIP CODE</b>		
<b>MAILING ADDRESS (IF DIFFERENT)</b>					<b>CITY</b>		<b>STATE</b>		<b>ZIP CODE</b>		
<b>HOME TELEPHONE NUMBER (including Area Code)</b>					<b>OTHER TELEPHONE NUMBER (including Area Code)</b>					<b>GENDER</b>	
					<input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/> Message					<input type="checkbox"/> Male <input type="checkbox"/> Female	
<b>MARITAL STATUS OF APPLICANT</b>					<b>EDUCATION</b>						
<input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Married <input type="checkbox"/> Unmarried Partner <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed					<input type="checkbox"/> 8 <sup>th</sup> Grade or less <input type="checkbox"/> Bachelor's Degree <input type="checkbox"/> 9 – 11 Grades <input type="checkbox"/> Graduate School <input type="checkbox"/> High School <input type="checkbox"/> No Schooling <input type="checkbox"/> Technical or Trade School						

**Does the applicant have a representative?**     Yes     No    If yes, name this person:

**APPLICANT'S USUAL HOUSING SITUATION**

<input type="checkbox"/> Adult Family Home	<input type="checkbox"/> Nursing Facility	<input type="checkbox"/> Own Home (with others)
<input type="checkbox"/> Child Foster Home	<input type="checkbox"/> Other's Home	<input type="checkbox"/> Parent's Home
<input type="checkbox"/> Group Home	<input type="checkbox"/> Own Home (alone): <input type="checkbox"/> Own <input type="checkbox"/> Rent <input type="checkbox"/> Subsidized	<input type="checkbox"/> Relative's Home
<input type="checkbox"/> Homeless	<input type="checkbox"/> Own Home (spouse/partner)	<input type="checkbox"/> State institution, psychiatric
<input type="checkbox"/> Correctional Facility	<input type="checkbox"/> Own Home (with dependent children)	<input type="checkbox"/> Unknown
<input type="checkbox"/> Licensed Staff Residential		

**Contact Person**

<b>NAME</b>					<b>RELATIONSHIP</b>						
<b>MAILING ADDRESS</b>					<b>CITY</b>		<b>STATE</b>		<b>ZIP CODE</b>		
<b>HOME TELEPHONE NUMBER (including Area Code)</b>					<b>OTHER TELEPHONE NUMBER (including Area Code)</b>					<b>E-MAIL ADDRESS</b>	
					<input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/> Message						
<b>MAIL CONTACT</b>		<b>RELATIONSHIP TYPE/ROLE</b>			<b>LEGAL RELATIONSHIP</b>				<b>LIVES WITH APPLICANT</b>		
<input type="checkbox"/> Yes <input type="checkbox"/> No									<input type="checkbox"/> Yes <input type="checkbox"/> No		

DESCRIBE THE DISABILITY AND THE AGE AT WHICH IT WAS OBSERVED.

<b>SIGNATURE OF ADULT APPLICANT</b>					<b>DATE</b>					
<b>SIGNATURE OF REPRESENTATIVE</b>					<b>LEGAL RELATIONSHIP</b>				<b>DATE</b>	

**SOURCE OF PERSONAL INCOME OF APPLICANT: CHECK ALL THAT APPLY**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Social Security                                | <input type="checkbox"/> Veteran's Administration       | <input type="checkbox"/> Civil Service          |
| <input type="checkbox"/> Supplemental Security Income (SSI)             | <input type="checkbox"/> Bureau of Indian Affairs (BIA) | <input type="checkbox"/> None                   |
| <input type="checkbox"/> General Assistance-Unemployable (GA-U)         | <input type="checkbox"/> Railroad retirement            | <input type="checkbox"/> Other (specify below): |
| <input type="checkbox"/> State supplement                               | <input type="checkbox"/> Trust funds                    |   |
| <input type="checkbox"/> Temporary Assistance for Needy Families (TANF) | <input type="checkbox"/> Earned income                  |   |

**Does the Applicant have any kind of Medical Coverage?**  Yes  No

If yes, please list.

<b>Medicare?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>If yes</b>
<b>MEDICARE NUMBER</b>	<b>TYPE</b>

**A. ETHNIC CODES (CHECK THE CORRECT CODE BELOW)**

<input type="checkbox"/> White	<input type="checkbox"/> Chinese	<b>Native Hawaiian/ Other Pacific Islander</b>	<b>B. Is the applicant Hispanic?</b>
<b>American or Alaska Native</b>	<input type="checkbox"/> Filipino		
<input type="checkbox"/> Eskimo	<input type="checkbox"/> Japanese	<input type="checkbox"/> Hawaiian	<input type="checkbox"/> No
<input type="checkbox"/> Aleut	<input type="checkbox"/> Korean	<input type="checkbox"/> Samoan	<input type="checkbox"/> Not Reported
<input type="checkbox"/> American Indian	<input type="checkbox"/> Laotian	<input type="checkbox"/> Guamanian	<input type="checkbox"/> Yes (If yes, indicate)
<b>Asian</b>	<input type="checkbox"/> Thai	<input type="checkbox"/> <b>Other Asian/Pacific Islander</b>	<input type="checkbox"/> Cuban
<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> <b>Other race</b>	<input type="checkbox"/> Mexican/Mexican American/Chicano
<input type="checkbox"/> Cambodian	<input type="checkbox"/> <b>Black or African American</b>	<input type="checkbox"/> <b>Unreported</b>	<input type="checkbox"/> Puerto Rican
			<input type="checkbox"/> Other Spanish/Hispanic

<b>PRIMARY LANGUAGE</b>	<b>SPEAKS ENGLISH</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Limited	<b>UNDERSTANDS ENGLISH</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Limited	<b>INTERPRETER REQUIRED</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>TRANSLATIONS REQUIRED</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
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<b>A</b>	<b>PRIMARY SIGNIFICANT OTHER NAME</b>	<b>STREET ADDRESS</b>	<b>CITY</b>	<b>STATE</b>	<b>ZIP CODE</b>
	<b>TELEPHONE NUMBERS</b>	<b>MAIL CONTACT</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>RELATIONSHIP TYPE/ROLE</b>	<b>LEGAL RELATIONSHIP TYPE/ROLE</b>	<b>LIVES WITH APPLICANT</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>B</b>	<b>SIGNIFICANT OTHER NAME</b>	<b>STREET ADDRESS</b>	<b>CITY</b>	<b>STATE</b>	<b>ZIP CODE</b>
	<b>TELEPHONE NUMBERS</b>	<b>MAIL CONTACT</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>RELATIONSHIP TYPE/ROLE</b>	<b>LEGAL RELATIONSHIP TYPE/ROLE</b>	<b>LIVES WITH APPLICANT</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>C</b>	<b>SIGNIFICANT OTHER NAME</b>	<b>STREET ADDRESS</b>	<b>CITY</b>	<b>STATE</b>	<b>ZIP CODE</b>
	<b>TELEPHONE NUMBERS</b>	<b>MAIL CONTACT</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>RELATIONSHIP TYPE/ROLE</b>	<b>LEGAL RELATIONSHIP TYPE/ROLE</b>	<b>LIVES WITH APPLICANT</b> <input type="checkbox"/> Yes <input type="checkbox"/> No

**FOR PERSONS UNDER 22 YEARS OF AGE**

<b>NAME OF SCHOOL/DAY PROGRAM</b> Experimental Education Unit (EEU)	<b>START DATE</b>
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<b>ADDRESS</b> University of Washington Box 357925	<b>CITY</b> Seattle	<b>STATE</b> WA	<b>ZIP CODE</b> 98195	<b>TELEPHONE NUMBER</b> 206-543-4011
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**SCHOOL DISTRICT NAME**

**COMMENTS**

**REQUEST FOR DDD ELIGIBILITY DETERMINATION  
INSTRUCTIONS FOR COMPLETION**

**Applicant Information**

The Applicant is the person for whom DDD Eligibility is being requested. Please fill in this section completely. If the Applicant does not have a telephone, please put *none*.

**Contact Person**

A Contact Person is someone who will be able to contact the Applicant or give us contact information, if we are unable to reach the Applicant. If there is no legal representative, the name of another person or advocacy entity that can assist if the Applicant is required for Necessary Supplemental Accommodation (NSA) purposes unless the Applicant requests in writing that notice not be sent to anyone else. (WAC 388-825-100)

**Legal Representative**

Legal Representative means: a parent of a child under eighteen; a person's legal guardian; a person's limited guardian when the limited guardian has authority over health care decisions; a person's attorney at law; a person's attorney in fact (someone with power of attorney who has been authorized to make health care decisions); or any other person who is authorized by law to act for the person in question.

**Applicant Usual Housing Situation**

Please check the box that best describes the place where the applicant lives.

**Describe the disability and the age at which it was observed.**

The answers to these questions will help us to understand the type of disability the applicant might have. If you need additional room, please use the back of the paper or another sheet.

**Applicant and/or Legal Representative Signature**

If the Applicant is under age 18, his or her parent or legal representative must sign and date the application. If the Applicant is age 18 or over, either the Applicant or his or her legal representative must sign and date the application.

**Sources of Income of Applicant**

Please check all that apply to the Applicant.

**Medical Coverage**

What type (if any) of medical coverage does the Applicant have? Please write in the type of coverage. If the Applicant has no medical coverage, please write *None*. Please fill in number and type of Medicare coverage if the Applicant has Medicare.

**Ethnicity of Applicant and the following section Hispanic**

Please check only one in each section.

**Language**

Please write in the Applicant's primary language, including American Sign Language (ASL) or other sign language, Braille, or if the Applicant uses a TDD or other communication device. If the Applicant requires an Interpreter, please check the box to indicate *YES*.

**Significant Others**

*Significant Others* are people in the life of the Applicant who are important or might be involved with the well-being of the Applicant. Examples are Biological or Adoptive Parents, Grandparents, Aunts, Uncles, Division of Children & Family Services Social Workers (for children), friends, advocates, and Legal Guardians. If you are uncertain about what to check under legal, you may use **Unknown**. In the case of a Guardianship, we will require copies of the court orders of Guardianship. If an Applicant is adopted, we will require copies of the legal adoption papers.

### **School/Day Program**

Any program which the Applicant attends on a daily basis, such as Early Intervention, school, or other program. If the Applicant does not attend any outside programs on a daily basis, please write *N/A*.

### **Additional Comments**

You may leave this blank, or make any additional brief comments that you think might be of assistance in determining Eligibility.

### **List of Required Attachments**

- Signed Application with all parts completed.
- Copies of any medical, or psychological assessments that indicate the Applicant's disability.
- Signed *Consent to Exchange Confidential Information* – be certain to include addresses and telephone numbers for all providers.
- Photocopy proof of Applicant's Residency in Washington State ( utility bill, voter registration, etc.) If the Applicant is a child, proof of custodial parent's residency.
- Signed HIPAA form (*Notice of Privacy Practices*).
- Copy of Social Security card or documentation of SSN, **if one exists**.
- Copy of Court Ordered Parenting Plan (if applicable).
- Copy of Guardianship papers (if applicable).
- Legal Adoption papers. (if applicable).

**This application cannot be accepted without all the required attachments. If you have questions, please call your local DDD office.**

The toll free numbers are:

Region 1	Spokane	1-800-462-0624	Region 4	Seattle	1-800-314-3296
Region 2	Yakima	1-800-822-7840	Region 5	Tacoma	1-800-248-0949
Region 3	Everett	1-800-788-2053		Bremerton	1-800-735-6740
	Bellingham	1-800-239-8285	Region 6	Tumwater	1-800-339-8227
				Vancouver	1-888-877-3490