REQUEST FOR SCREENING FOR
INDIVIDUAL AND FAMILY DEVELOPMENTAL DISABILITIES SUPPORT WAIVER
(DD WAIVER)

This is a request to be screened for the Individual and Family Developmental Disabilities Support Waiver. Submission of this request form does not guarantee admission into the waiver, nor does it guarantee Medicaid eligibility. Complete the form in its entirety and mail to the Screening Facility (Child Development Clinic or Health Department) closest to your area.

Name of parent or responsible party (please PRINT):_____

Home phone (with area code):_____Work/Cell phone:_____

Name of person to be screened (Print):_____
Last First

Check one: ___Male ___Female Date of application:_____

Address: _____
Street Address
_____
City State Zip
County (if applicable): _____

***Date of birth: _____Age: _____ Social Security Number:_____**
Individuals must be 6 years of age or older and cannot have a diagnosis of Mental Retardation to be eligible for this waiver.

Are you currently Medicaid eligible? ___ Yes ___No
- **If yes, please provide 12 digit Medicaid number:_____**
- **What services are you currently receiving under Medicaid?_____**

_____

Signature of Person making request for screening:_____
Name of Person making request (PRINT): _____
Relationship to Person to be screened:_____
Phone Number of Person making request (if different from above): _____

Completed applications must be submitted to the Screening facility closest to your home. Forms sent to DMAS will not be processed.

FOR SCREENING TEAM USE ONLY

Date Application Received: ___/___/___
Signature of Receiver:_____
Date(s) Contact Made With Applicant:_____
Date Screening Performed: ___/___/___
Service Approved? If Approved, which service? ICF/MR DD Waiver
Service Not Approved? If Not Approved, Reason:_____
Date Applicant Notified: ___/___/___ (Attach copy of letter to this request)