

## Request for DDA Eligibility Determination

**FOR OFFICE USE ONLY**

Initial       Reapplication  
DDA NUMBER:

Applicant Information				
LAST NAME	FIRST NAME	MIDDLE NAME / INITIAL	BIRTHDATE	SOCIAL SECURITY NUMBER
ADDRESS		CITY	STATE	ZIP CODE
MAILING ADDRESS (IF DIFFERENT)		CITY	STATE	ZIP CODE
HOME TELEPHONE NUMBER (INCLUDING AREA CODE)		OTHER TELEPHONE NUMBER (INCLUDING AREA CODE) <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/> Message		GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female
MARITAL STATUS OF APPLICANT <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		EDUCATION <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? <input type="checkbox"/> Yes <input type="checkbox"/> 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"/> Relative's Home
<input type="checkbox"/> Homeless		<input type="checkbox"/> Own <input type="checkbox"/> Rent <input type="checkbox"/> Subsidized		<input type="checkbox"/> State institution, psychiatric
<input type="checkbox"/> Correctional Facility		<input type="checkbox"/> Own Home (spouse/partner)		<input type="checkbox"/> Unknown
<input type="checkbox"/> Licensed Staff Residential		<input type="checkbox"/> Own Home (with dependent children)		
Contact Person				
NAME			RELATIONSHIP	
MAILING ADDRESS		CITY	STATE	ZIP CODE
HOME TELEPHONE NUMBER (INCLUDING AREA CODE)		OTHER TELEPHONE NUMBER (INCLUDING AREA CODE) <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/> Message		E-MAIL ADDRESS
MAIL CONTACT <input type="checkbox"/> Yes <input type="checkbox"/> No	RELATIONSHIP TYPE / ROLE		LEGAL RELATIONSHIP	LIVES WITH APPLICANT <input type="checkbox"/> Yes <input type="checkbox"/> No
DESCRIBE WHY YOU ARE APPLYING AND DESCRIBE THE DEVELOPMENTAL DISABILITY AND THE AGE AT WHICH IT WAS FIRST OBSERVED				
SIGNATURE OF ADULT APPLICANT			DATE	
SIGNATURE OF REPRESENTATIVE		LEGAL RELATIONSHIP		DATE

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 Supplemental Payment                     | <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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes
If yes, please list.	MEDICARE NUMBER	TYPE

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

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

<b>B</b>	SIGNIFICANT OTHER NAME	STREET ADDRESS		CITY	STATE	ZIP CODE
	TELEPHONE NUMBERS	MAIL CONTACT <input type="checkbox"/> Yes <input type="checkbox"/> No	RELATIONSHIP TYPE / ROLE	LEGAL RELATIONSHIP TYPE / ROLE	LIVES WITH APPLICANT <input type="checkbox"/> Yes <input type="checkbox"/> No	

<b>C</b>	SIGNIFICANT OTHER NAME	STREET ADDRESS		CITY	STATE	ZIP CODE
	TELEPHONE NUMBERS	MAIL CONTACT <input type="checkbox"/> Yes <input type="checkbox"/> No	RELATIONSHIP TYPE / ROLE	LEGAL RELATIONSHIP TYPE / ROLE	LIVES WITH APPLICANT <input type="checkbox"/> Yes <input type="checkbox"/> No	

**FOR PERSONS UNDER 22 YEARS OF AGE**

NAME OF SCHOOL / DAY PROGRAM	START DATE
ADDRESS	CITY STATE ZIP CODE TELEPHONE NUMBER

SCHOOL DISTRICT NAME

COMMENTS

**REQUEST FOR DDA ELIGIBILITY DETERMINATION  
INSTRUCTIONS FOR COMPLETION**

**Applicant Information**

The Applicant is the person for whom DDA 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. The name of a contact is for Necessary Supplemental Accommodation (NSA) purposes. The Applicant may request in writing that notice(s) 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 of medical coverage (if any) does the Applicant have? Please write in the type of coverage. If the Applicant has no medical coverage, write *None*. If the Applicant has Medicare, fill in the number and type of Medicare coverage.

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

Please check the applicable boxes.

**Language**

Please write in the Applicant's primary language or communication method, 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, 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, submit copies of the court orders of Guardianship. If an Applicant is adopted, submit 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, 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**

This application cannot be accepted without the 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* –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).

**Return the application and required attachments to the corresponding office below. If you have questions, please call your DDA office.**

**Region 1 Headquarters (Counties served:** Adams, Asotin, Benton, Chelan, Columbia, Douglas, Ferry, Franklin, Garfield, Grant, Kittitas, Klickitat, Lincoln, Okanogan, Pend Oreille, Spokane, Stevens, Walla Walla, Whitman, Yakima)

1611 W INDIANA AVE  
SPOKANE WA 99205-4221  
Toll Free: 1-800-462-0624

**Region 2 Headquarters (Counties served:** Island, King, San Juan, Skagit, Snohomish, Whatcom)

20311 52<sup>ND</sup> AVE W STE 302  
LYNNWOOD WA 98036-3901  
Toll Free: 1-800-788-2053

**Region 3 Headquarters (Counties served:** Clallam, Clark, Cowlitz, Grays Harbor, Jefferson, Kitsap, Lewis, Mason, Pacific, Pierce, Skamania, Thurston, Wahkiakum)

1305 TACOMA AVE S STE 300  
TACOMA WA 98402-1903  
Toll Free: 1-800-248-0949