

**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)