

# DDD ELIGIBILITY PACKET

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# How DDD Eligibility is Determined

## A. Age 0 (birth) to 3:

For early intervention services, children age birth to three must have a significant delay in one or more developmental areas or an established condition that could lead to a developmental disability. To make a referral for a child, please contact the AzEIP Central Referral Line (Raising Special Kids) toll-free at (800)237-3007 or by e-mail at [AzEIP.Info@raisingspecialkids.org](mailto:AzEIP.Info@raisingspecialkids.org). Once a child has been made eligible for AzEIP, with the family's consent, DDD eligibility will be determined.

## B. Age 3 to 6:

A person must **1)** voluntarily apply, **2)** be an Arizona resident, and **3)** either have one of the following developmental disabilities: Autism Spectrum Disorder, Cerebral Palsy, Intellectual (Cognitive) Disability, Epilepsy or the child is At-Risk for developing one of these disabilities. (Cognitive) Disability, Epilepsy or the child is At-Risk for developing one of these disabilities.

Question	Requirements
<b>How do I know?</b>	A developmental assessment, provided by a medical professional or school evaluator trained in childhood development, can be used to identify a developmental delay that could lead to a developmental disability.
<b>Who can provide the information to me?</b>	Professionals trained in early childhood development include: <ul style="list-style-type: none"> <li>Licensed Physician</li> <li>School Psychologist</li> <li>Early Childhood Education Specialist</li> <li>Nurse Practitioner</li> <li>Physician's Assistant</li> <li>Licensed Psychologist</li> <li>Pediatrician</li> <li>Child Neurologist</li> </ul>
<b>Are there other disabilities accepted?</b>	Yes: Spina Bifida with Arnold Chiari Malformation, Periventricular Leukomalacia, Chromosomal Abnormalities with high risk for Intellectual Disability (such as Down Syndrome), Post-Natal Traumatic Brain Injury (such as Shaken Baby Syndrome or near drowning), Hydrocephaly, Microcephaly, disorders due to drug or alcohol (such as Fetal Alcohol Syndrome), and birth weight under 1000 grams with neurological impairment.

## C. Age 6 to Adult:

A person must **1)** voluntarily apply, **2)** be an Arizona resident, and **3)** be diagnosed with a developmental disability (listed below) which developed before the age of 18 and is likely to continue indefinitely, and **4)** there must also be significant limitations in daily life skills related to the disability (see next page).

Diagnosis	Requirements
CEREBRAL PALSY	The evaluation report must include a description of how the practitioner came to the decision regarding the diagnosis. <i>DDD accepts evaluations by a licensed physician.</i>
EPILEPSY	The evaluation report must include a description of how the practitioner came to the decision regarding the diagnosis. <i>DDD accepts evaluations by a licensed physician.</i>
AUTISM SPECTRUM DISORDER	The evaluation report must include a description of how the practitioner came to the decision regarding the diagnosis. <i>DDD accepts evaluations by a Psychiatrist, Licensed Psychologist, Child Neurologist, Developmental Pediatrician and Pediatricians with specialized training in Autism.</i>
INTELLECTUAL (COGNITIVE) DISABILITY	The evaluation report must include standardized intellectual testing (IQ) and adaptive behavior testing that leads to the diagnosis or Special Education category of Intellectual Disability. The Individual Education Plan (IEP) and Multidisciplinary Evaluation Team report (MET) can be used together. <i>DDD accepts evaluations by a licensed psychologist, certified school psychologist or psychometrist working under a licensed psychologist or certified school psychologist.</i>

## Substantial Functional Limitations:

In addition to being diagnosed with at least one developmental disability, the person must show significant limitations in daily life skills due to their qualifying diagnosis in three (3) of the following. (Note: The age of the person is taken in to consideration when identifying significant limitations in daily life skills.)



### RECEPTIVE AND EXPRESSIVE LANGUAGE

- Cannot communicate with others
- Cannot communicate effectively without the assistance of others or a mechanical device



### LEARNING

- Cannot participate in age appropriate learning without assistance



### SELF-DIRECTION

- Needs assistance with making decisions that affect their well being
- Does not have safety awareness skills
- Needs help with personal finances



### SELF-CARE

- Needs significant help with bathing, toileting, tooth brushing, dressing and grooming (taking care of themselves)
- The time to complete self-care activities takes so long it affects attendance or success in school, employment or other activities of daily living



### MOBILITY

- Fine and motor skills are impaired
- Needs assistance from a mechanical device like a wheelchair or a walker to move from place to place
- The time it takes for the person to move takes so long that it affects keeping a job or completing activities of daily living



### CAPACITY FOR INDEPENDENT LIVING

- Needs daily supervision to help with health and safety
- This includes completing household chores, preparing simple meals, using microwaves or other household equipment, using public transportation and shopping for food and clothing



### ECONOMIC SELF-SUFFICIENCY

- Can't perform tasks to keep a job
- Is limited in what they can earn
- Considering all expenses and the disability, the person earns below federal poverty level

For Questions Call Toll Free 1-844-770-9500 or E-mail [DDDApply@azdes.gov](mailto:DDDApply@azdes.gov)

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

ARIZONA DEPARTMENT OF ECONOMIC SECURITY  
Division of Developmental Disabilities

## DDD ELIGIBILITY CHECKLIST

### What is a complete packet?

What do I need?	What is it?	Why do I need it?	Do I have it?
Hand signed Application for Eligibility Determination (DDD-1972A)	Four-page document that asks for information about you and your child or the person you are applying for. It allows us to work with other people or agencies to help you.	DDD needs information about you or your child in order to decide if you or your child is eligible.	Yes No
Copy of birth certificate (or citizenship / immigration document)	Documentation demonstrating citizenship or lawful presence in the United States.	The State of Arizona requires that DDD help people who are born in the United States or have legal residency in the United States. There are other documents you can show us to meet this requirement. Ask your eligibility specialist if you need another option.	Yes No
Proof of Arizona residency (lease, utility bill, State ID/Driver License)	Documentation showing the applicant's name and current residential address.	The state of Arizona requires all recipients to be residents of Arizona at the time of the application.	Yes No
Health Coverage, copy of front / back (if applicable)	A card or document given to you when you have health insurance coverage by the state or a private insurance company.	Your insurance company may have the responsibility to pay for medical costs before DDD pays for some or all the cost.	Yes No
Records showing a qualifying disability	Documents by a school and / or doctor that show you or your child has a disability. (See DDD-0640A "How DDD Eligibility is Determined" flyer for information based on age and disability).	DDD needs to know if your child or the person you are applying for has a qualifying disability. <ul style="list-style-type: none"> <li>• Cerebral Palsy</li> <li>• Epilepsy</li> <li>• Autism Spectrum Disorder</li> <li>• Intellectual (Cognitive) Disability</li> </ul> At Risk for one of the above (under age 6 only).	Yes No
School Evaluation Documents (if applicable)	A report showing observations and tests that helps decide if your child needs help at school. A document that shows how the school will meet your child's needs. (Individual Education Plan (IEP) and Multidisciplinary Evaluation Team (MET) or Psychoeducational report).	It helps us determine if your child meets DDD eligibility requirements.	Yes No
Documents Showing Legal Responsibility / Guardianship (if applicable)	Court-issued or legal document showing who has the right to make legal decisions.	DDD needs to know who has the right to make legal decisions about your child or the person applying.	Yes No

If you have any questions, please call our DDD Customer Service Center at 1-844-770-9500  
or email your question to [DDDApply@azdes.gov](mailto:DDDApply@azdes.gov).

## APPLICATION FOR ELIGIBILITY DETERMINATION

### HOW TO APPLY:

**STEP 1)** Complete the DDD Eligibility Checklist ([DDD-1991A](#)) for a **complete packet** guide

**STEP 2)** Complete and hand-sign pages 2, 3 & 4 of this application (DDD-1972A)

**STEP 3)** Gather documents that support one of the four qualifying diagnoses and substantial limitations (see [DDD-0640A](#)):

Copy of U.S. birth certificate OR citizenship / immigration (*ex: refugee, legal status, etc.*)

Written proof of Arizona residency showing the applicant's name and residential address (*ex: applicant's Arizona driver's license, Arizona identification card or Arizona motor vehicle registration; utility bill, lease, mortgage or rent receipt; certified copy of a school record; or signed employment statement from applicant's non-relative employer*)

Guardianship / Legal responsibility documents (*if applicable*)

Copy of all medical insurance cards (*front / back*)

Diagnosis evaluation / School report showing proof of the lifelong condition. **Check all that apply:**

Autism Spectrum Disorder      Cerebral Palsy      Intellectual (cognitive) Disability      Epilepsy

At Risk for one of them (if under the age of 6 only)

**STEP 4)** After reviewing the previous steps and what is required, are you ready to apply now?      Yes      No

If **NO**, please apply when you have a **complete packet** or call 1-844-770-9500 to speak with a DDD Eligibility Specialist. If **YES**, continue to submit your application and supporting documents by **1)** email to [DDDAPPLY@azdes.gov](mailto:DDDAPPLY@azdes.gov); **2)** Walk-in drop off and have the office send the completed application to [DDDAPPLY@azdes.gov](mailto:DDDAPPLY@azdes.gov).

#### Flagstaff

#### Chandler

#### Phoenix (Central)

#### Phoenix (West)

#### Tucson

[DDDAPPLY@azdes.gov](mailto:DDDAPPLY@azdes.gov)

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### SECTION A. (Applicant Information)

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex:      Male      Female

AHCCCS A Number (*If applicable*): \_\_\_\_\_ Primary Language: \_\_\_\_\_

Home Address (*No., Street*): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_ Phone: \_\_\_\_\_

Ethnicity: \_\_\_\_\_ Tribe (*If applicable*): \_\_\_\_\_

Mailing Address (*If applicable*): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Contact Preference:      Phone      Email      Both \_\_\_\_\_

Do you want to register to vote?      Yes      No

### SECTION A.1

#### Professionals who can provide records for all qualifying disabilities:

- Licensed psychologist
- Psychiatrist
- Neurologist
- School psychologist
- Pediatrician
- Early intervention team

*Professionals accepted vary by disability. Ask your eligibility specialist if you have questions.*

Names and Contact Information	Type of Professional	Date of Evaluation

## SECTION B. (Parent/Foster parent, if applicable)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Address (If different than applicant): \_\_\_\_\_ Alt: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_ Best way to contact you: \_\_\_\_\_

Legal Guardian Name (If different than above): \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

(Legal guardian is a person who is appointed by a judge.)

## SECTION C. Health Insurance

Type of Coverage (private, public, etc.)	Name of Health Plan	Policy Holder Name	ID/Group # and Policy #	Effective Date	Policy Holder's Date of Birth

## SECTION D. (Early Intervention and Educational History, if Applicable)

Early Intervention Program State or School Name and School District	Type of Support (Services or type of plan such as Individual Education Plan or 504 Plan)	Dates Attended

### By signing below, I agree that:

- I am applying as a or for the person named above who is a resident of the State of Arizona.
- I have been informed of the services provided by this agency.
- I understand that if I am referred to AHCCCS for an ALTCS eligibility determination, I must cooperate in this determination process.
- As part of my application to this division, I have been informed of the DDD eligibility criteria and of my rights relevant to the application process.
- Applicants are required to assign rights to insurance benefits in accordance with R6-6-1303. If I am eligible and assigned to services, I authorize the release of information necessary to file a claim to my insurance company.
- I attest that everything I have stated in this application is true.

### Who can sign the application?

- An applicant over 18 years of age without a court appointed legal guardian
- A biological or adoptive parent applying for a minor child (including children in foster care where parental rights have not been terminated)
- A Child Safety Specialist from the Department of Child Safety, for children in foster care if the biological/adoptive is unavailable (must have documentation showing reasonable efforts to obtain biological/adoptive parent signature)
- A legal guardian, appointed by a court (need to have documents of guardianship)

Name (Please print): \_\_\_\_\_

Relationship to Applicant (i.e. parent, court appointed guardian, self): \_\_\_\_\_

Responsible Person's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Hand signed signature required)

**AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION**  
**Health Insurance Portability and Accountability Act (HIPAA) Act of 1996 45 C.F.R. 164.508**Name of Individual/Client whose health information will be shared (*Last, First, Middle*):

Date of Birth: \_\_\_\_\_

Describe what this information will be used for and why it is needed:

I authorize **Arizona Department of Economic Security, Division of Developmental Disabilities (DDD)** to disclose (share) protected health information described above to the individual/agency below.

Individual/Agency requesting or needing information:

Date of Request: \_\_\_\_\_

By signing this Authorization, I understand that:

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.

I do not have to sign this authorization. I understand that a health care provider or health plan may not condition treatment, payment, enrollment or eligibility in a health plan or eligibility for health care benefits on my signing this authorization except as provided under state or federal law.

- 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.
- This authorization shall expire a year from the date below.

Printed Name of Parent or Legal Guardian: \_\_\_\_\_

Signature of Parent or Legal Guardian: \_\_\_\_\_ Date of Authorization: \_\_\_\_\_

**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: \_\_\_\_\_

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



# How do I find out if I qualify for the Division of Developmental Disabilities?



DEPARTMENT OF ECONOMIC SECURITY

*Your Partner For A Stronger Arizona*

## APPLICATION REQUIREMENTS AGE 3 TO ADULT

- Complete, signed application
- Applicant must be Arizona resident
- Documentation showing legal status
- Copy of medical insurance (if applicable)
- Copy of diagnosis evaluation/report
- Individual Education Plan (IEP) and Multidisciplinary Evaluation Team (MET) or Psychoeducational school report.

**\*For “Birth Until Age 3” See AzEIP**

### BIRTH UNTIL AGE 3

#### **\*AzEIP**

- Arizona Early Intervention Program
- Contact Raising Special Kids
- Phone: (800) 237-3007
- Complete Referral at [des.az.gov/azeipref](http://des.az.gov/azeipref)

### AGE 3 UNTIL AGE 6

#### **QUALIFYING DIAGNOSIS**

- Cerebral Palsy
- Epilepsy
- Intellectual (cognitive) Disability
- Autism Spectrum Disorder
- Or be at risk of developing one of these disabilities
- Exhibit “significant delay” in one or more areas that could lead to a developmental disability

### AGE 6 TO ADULT

#### **QUALIFYING DIAGNOSIS**

- Cerebral Palsy
- Epilepsy
- Intellectual (cognitive) Disability
- Autism Spectrum Disorder

Must have one or more of the qualifying diagnoses and provide documentation that the disability started before the age of 18.

#### **SUBSTANTIAL FUNCTIONAL LIMITATIONS**

  
Receptive and Expressive Language

  
Learning

  
Self-Direction

  
Self-Care

  
Mobility

  
Capacity for Independent Living

  
Economic Self-Sufficiency

Qualifying applicants must have 3 or more S.F.L. due to the qualifying diagnosis

**Member eligibility is “re-determined” at ages six (6) and eighteen (18) to verify the member is eligible and in need of DDD services.**

DDD-1954A POSENG (12-20)

**FOR MORE INFORMATION PLEASE CALL 1 (844) 770-9500 OR EMAIL [DDDAPPLY@AZDES.GOV](mailto:DDDAPPLY@AZDES.GOV)**