

**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. Fill the request form, print, sign, and mail to the Child Development Clinic closest to your area.*

Name of person to be screened: _____
Last
First
SS#

Address (include city, state, zip): _____

County: _____ Phone Number (include area code): (____) _____

*Date of Birth: _____

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, provide 12-digit Medicaid identification number: _____
- What services are you currently receiving under Medicaid: _____

Signature of Person Making Request for Screening: _____

Date: _____

Completed applications must be submitted to your local Child Development Clinic. 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?: <input type="checkbox"/> If Approved, which service? <input type="checkbox"/> ICF/MR <input type="checkbox"/> DD Waiver
Service Not Approved?: <input type="checkbox"/> If Not Approved, Reason: _____
Date Applicant Notified: ___/___/___ (Attach copy of letter to this request)