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Idaho Department of Health and Welfare	RegionField Office
CLIGIBILITY APPLICATION FOR ADULTS	Date Received
WITH DEVELOPMENTAL DISABILITIES	

Name	Date of Birth	
Address		
	Telephone	
Current Living Arrangement		
Referral Source, if other than self		
	Yes, Medicaid NumberName	
of Physician	Enrolled in Healthy Connections? No Yes	
What services are you seeking?		
DD Waiver Traditional Sel	lf-Directed Community Supports	
Developmental Disabilities Agencies (	* **	
☐ ICF/ID		
Service Coordination		
Other (please specify)		
	Family Member/Contact (or unpaid advocate)	
Address	•	
Telephone	Telephone	
The following information is needed to de	etermine eligibility. If it does not accompany this application, indicate	
	I for written authorization to release information.	
Evaluation Information	Source or Address of Information	
Functional Assessment		
Medical/Social History		
Psychological Evaluation (may be requested)		
	eel may be helpful in making a determination of developmental disability.	
Trease account any other information you re		
DD Eligibility	Approved   Denied	
DD Waiver Services Eligibility	Approved Denied	
Reason for Denial:		
Signature of Authorized Representative	ve of the Department:	
Date		

If you are eligible for and will receive Service Coordination and/or DD/Waiver services, a Plan Developer will assist you to develop a plan of services. If you participate in the Self Directed Community Supports program you will select a Support Broker to assist you to develop a plan of services.