ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

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 five 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) ☐ Down Syndrome

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; **2)** Walk-in drop off and have the office send the completed application to DDDAPPLY@azdes.gov.

Flagstaff	**Chandler**	**Phoenix** (Central)	**Phoenix** (West)	**Tucson**
DDDAPPLY@azdes.gov	DDDAPPLY@azdes.gov	DDDAPPLY@azdes.gov	DDDAPPLY@azdes.gov	DDDAPPLY@azdes.gov

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: _____

Do you want to register to vote? ☐ Yes ☐ No

SECTION A.1

Professionals who can provide records for all qualifying disabilities:

- Licensed psychologist
- School psychologist
- Psychiatrist
- Pediatrician
- Neurologist
- Early intervention team
- Neonatologist
- Certified Geneticist
- Licensed Primary Care Physician

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

Names and Contact Information	Type of Professional	Date of Evaluation

See page 3 for EOE/ADA/LEP/GINA disclosures

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)