

Developmental Disabilities Administration Low Intensity Support Services (LISS) Request Form

APPLICANT INFORMATION

Last Name:	First:	Middle:	Marital Status (circle one) Single Married Div Sep Widow	
Address:	City:	State:	Zip Code:	Sex: M / F
	County:			
Cell Phone #	Day/Work #		Home #	
Email Address: (If applicable)				
Social Security #:	Date of Birth:		Age:	
Medical Assistance #: If none, date of application (For applicant over the age of 18):				

Demographic Information - (for internal use only - does not apply to eligibility)

Individual's Annual Income (optional):	Household Annual Income (optional):
Primary Disability:	Race(circle one): Black/African American White/Caucasian Asian Hispanic Other American Indian/Alaska Native American Pacific
What is the relationship of the person completing this form to the applicant? ___ Self ___ Parent ___ Spouse ___ Guardian ___ Resource/Service Coordinator ___ School Counselor ___ Other :	
If not "self", please note name of person completing this form:	Phone #:

Please check all programs and services the applicant is currently receiving services or resources from:

DDA: <input type="checkbox"/> Resource/Service Coordination <input type="checkbox"/> Day/Supported Employment <input type="checkbox"/> CSLA <input type="checkbox"/> Supports <input type="checkbox"/> Community Pathways or New Directions	MA Waivers: <input type="checkbox"/> Autism <input type="checkbox"/> Model <input type="checkbox"/> Traumatic Brain Injury <input type="checkbox"/> Living at Home <input type="checkbox"/> Older Adults <input type="checkbox"/> Medical Day Care <input type="checkbox"/> RTC (Residential Treatment Center)
OTHERS: <input type="checkbox"/> Special Education <input type="checkbox"/> Division of Rehabilitation Services (DORS) <input type="checkbox"/> Food Bank <input type="checkbox"/> Transportation	<input type="checkbox"/> REM (Rare & Expensive Case Management) <input type="checkbox"/> MA Personal Care <input type="checkbox"/> In-Home Aid Services (DSS) <input type="checkbox"/> Attendant Care Program <input type="checkbox"/> Social Services <input type="checkbox"/> Energy Assistance (MEAP) <input type="checkbox"/> Housing <input type="checkbox"/> Other:

Resource/Service Coordinator/Case Manager Name:	Phone #:
Address:	Email:



SERVICE/ITEM REQUEST

Eligible Support/Activity/Item	Name, Address & Telephone # of Provider of Support/Activity/Item (To whom the payment is made)	Cost of Support/Activity/Item	Dates of Support/Activity	Documentation of cost (This must be included)	FOR RESPITE REQUEST ONLY <input type="checkbox"/> NAME OF PROVIDER <input type="checkbox"/> DAILY RATE <input type="checkbox"/> AMOUNT OF DAYS
EXAMPLE: -Summer Camp	ABC CAMP 123 Any Way Anywhere, MD 12345 410-222-2222	\$660.00	June 20 - August 25	YES	
1.					
2.					
3.					

Where else has funding been sought and the status? (i.e. application pending, denied, or the amount funded)

1.	
2.	
3.	
Applicant's Contribution (if any):	

APPLICANTS ARE REQUIRED TO SUBMIT APPROPRIATE DOCUMENTATION INCLUDING A COPY OF THE SOCIAL SECURITY CARD, PROOF OF RESIDENCY, AND PROOF OF DEVELOPMENTAL DISABILITY IN ORDER FOR ELIGIBILITY TO BE CONSIDERED.

Applicant Declaration

By signing this application, I hereby attest that the information provided to process the Low Intensity Support Services (LISS) funding request is accurate to the best of my knowledge. I understand LISS funding is not an entitlement program, and receipt of LISS funds is on a first come, first serve basis. LISS funding is contingent upon DDA's LISS eligibility criteria, verification of the above information, and funding availability.

Signature of Applicant: _____ Date: _____
Name (Print): _____

Person designated to receive correspondence: _____ Date: _____
Name (Print): _____