

DDRR application form

State of Alaska (http://alaska.gov) State of Alaska (http://dhss.alaska.gov)
Public Notices (http://http://www.hss.state.ak.us/publlcnnotice/) myAlaska (http://myalaska.state.ak.us/)



Developmental Disabilities Waiting List Registration and Review
Applicant (#Applicant), Legal Representative (#LegalRep), Person completing form (#Submitter), Review of
current life concerns (#Review), Service needs (#Service)

Please provide the following information for the applicant/person needing DD services.

Items in red are required

Applicant

First Name Middle Initial Last Name DSIDS ID

Addresses

Mailing Address City State Zip

Physical address is same as mailing address [checkbox]

Physical Address City State Zip

Date of birth (mm/dd/yyyy) Gender Male Female Marital Status Single Married

Phones

Home phone Mobile phone Work phone

Email Address

Preferred Method of Contact Mail Telephone Email

Ethnicity

Alaska Native / American Indian Asian Black Hispanic Pacific Islander White

Other

Applicant eligible for Alaska Native/Indian Health Services benefits? [checkbox]

Applicant enrolled in Medicaid/Denali Kid Care/TEFRA? Medicaid #

In the next 12 months, applicant would accept:

- Developmental disabilities grant services
Home and community based Medicaid waiver services
Either program (Eligibility criteria, available funding, and location may influence the program you may be selected for.)

Legal Representative

First Name Last Name

Addresses

Mailing Address City State Zip

Physical address is same as mailing address [checkbox]

Physical Address City State Zip

Phones

Home phone

Mobile phone

Work phone

Email Address

Preferred Method of Contact  Mail  Telephone  Email

State agency interest

Public Guardian  Office of Children's Services (OCS) Custody (OPA)

Representative type

Parent  Conservator  
 Delegated Parental Authority  Power of Attorney  
 Full Guardian  Representative Payee  
 Partial Guardian  Unknown  
Other

Contact Person

If you do not have a legal representative, please provide the contact information of anyone who assists you. We will copy your eligibility and Registry mail to the person indicated. Please ensure this name is also listed on the Release of Information.

You can fax the Release of Information to (907) 269-3638 or e-mail it to [ddmailbox@alaska.gov](mailto:ddmailbox@alaska.gov) (<mailto:ddmailbox@alaska.gov>)

Form fields for Contact Person: First Name, Last Name, Relationship, Mailing Address, Physical address, City, State, Zip, Phones (Home, Mobile, Work), Email Address, Preferred Method of Contact.

Person completing form (If different from legal representative or applicant)

If the applicant is completing this form, click this button to copy their information

If the legal representative is completing this form, click this button to copy their information  If the contact person is completing this form, click this button to copy their information

Form fields for Person completing form: First Name, Last Name, Addresses (Mailing, Physical), City, State, Zip, Phones (Home, Mobile, Work), Email Address, Preferred Method of Contact.

**Review of Current Life Concerns**

Please review the following list of community participation, living situation, and caregiver concerns.

Provide the additional information or description requested after each checked item. Scoring will be based on the information provided. No points will be given if the required additional information or description has not been included.

Consider the level of need for supports and services for the problems created by each of the concerns checked. Show the level of need after each checked item by marking a number from 1 - 4.

Use the following as a guide to help decide the level of need:

- 1. = **No need/Not applicable:** no services needed at this time, but possible need in the future.
- 2. = **Minor need:** manageable problems, but additional supports and services would help.
- 3. = **Moderate need:** some problems needing supports and services to manage.
- 4. = **Major need:** difficult problems needing extensive supports and services.

**Community Participation Concerns**

**Level of Need**

1. Behavior which causes physical harm to self or others. Injures self (scratches, bites, etc.) or physically assaults others. 1   2   3  
     

4

The behavior **MUST** be described below:

2. Behavior which interferes with home and/or community life. Frequent, challenging behavior resistant to interventions. 1   2   3  
     

4

The behavior **MUST** be described below:

3. Behavior leading to justice system involvement. Within the last five years, arrested, charged, jailed, or placed on probation; continues to engage in behaviors likely to result in further involvement in the juvenile or adult justice system. No  
  
Yes

Date of most recent justice system contact (mm/dd/yyyy)  
Current status of applicant  
If in jail, anticipated date of release (mm/dd/yyyy)

Please provide any additional information

4. Victim of psychological, physical, sexual, and/or financial abuse. 1   2   3  
     

4

The circumstances **MUST** be described below:

5. Complex, chronic medical condition Requires on-going care and frequent attention by medical professionals, and routine supervision regarding medical needs. 1   2   3

4 The condition  
 **MUST** be  
 described below

6. Applicant is caring for children or will be parent within eight months.

1 2 3

4

The circumstances **MUST** be described below; include names and ages of children and/or estimated due date:

**Living Situation Concerns**

**Level of Need**

7. Death of primary caregiver within the past 12 months.

No

Yes

Name of caregiver

Date of death

(mm/dd/yyyy)

Please provide any additional information:

8. No long-term caregiver available to assist with daily care needs.

1 2 3

4

Name of temporary caregiver

Relationship to applicant

End date of temporary care

(mm/dd/yyyy)

Please provide any additional information:

9. Homeless. No fixed, regular and adequate night-time residence. Spends nights at a supervised shelter providing temporary living, or at a public or private place not intended to be used as a night-time residence for humans; or is facing discharge from an institution within one week, but has no residence or resources to obtain shelter.

1 2 3

4

Location of night time residence

Length of time applicant has been

homeless

Date of discharge from institution (if applicable)

(mm/dd/yyyy)

Please provide any additional information:

10. Discharge from foster care/Office of Children's Services within a year. Living in foster care, but will be 18 within a year, and is at risk of being homeless because no caregiver has been identified.

1 2 3

4

information

Please provide any additional

11. Current residence is a nursing home, psychiatric treatment facility/hospital or intermediate care facility for the mentally retarded (ICF/MR).

No  
  
Yes

Treatment Facility Name

Date of admission

(mm/dd/yyyy)

Please provide any additional information:

**Caregiver Concerns**

**Level of Need**

12. Caregiver unable to provide adequate care. Age, health, physical or psychological condition affects ability to continue providing care.

1 2 3  
    
4

The circumstances **MUST** be described below, include caregiver's birth date if age is a factor

13. Caregiver is unable to meet behavior or health needs of applicant. Supports, skills or training is insufficient to meet applicant level of need.

1 2 3  
    
4

The circumstances **MUST** be described below:

14. Caregiver unable to get or hold a job. Needs of applicant interfere with caregiver ability to find or keep employment; resources and options for applicant care during work day have been exhausted.

1 2 3  
    
4

The circumstances **MUST** be described below:

**Service Needs**

SDS grants and programs make a variety of services available. The availability of a specific service will depend on the funding source. All services are subject to the limitations and requirements of state and federal regulations.

Consider the service descriptions below, and determine which services are needed now, and which might be needed in the future.

Check either the "Now" box or a multi-year box (1-2 yrs., 3-4 yrs., or 5-10 yrs.) following the description

**Service**

Now 1-2 yrs 3-4 yrs  
5-10 yrs

Services coordination to gain access to, plan for, and monitor delivery of: medical, social, educational, and other services.

**In-home supports:** Services to help applicants acquire, retain, and/or improve self-help and social skills while living full time in the home of an unpaid caregiver.

**Family habilitation:** Services in a family-like setting to help applicants acquire, retain, and/or improve self-help and social skills while living full-time in the licensed home of a paid caregiver.

**Shared care:** Services in a family-like setting to help applicants acquire, retain and/or improve self-help and social skills while living part time in the licensed home of a paid caregiver.

**Group home:** Services in a group setting to help applicants, age 18 or older, acquire, retain and/or improve self-help and social skills while living full time in a licensed assisted living home

**Supported living:** Services in an independent setting to help applicants, age 18 or older, acquire, improve, and/or retain self-help and social skills while living full time in their own residences.

**Day habilitation:** Services (recreational and other activities) outside the home to help applicants acquire, improve, and/or retain self-help and social skills needed to participate in community life.

**Respite:** Relief services for caregivers which offer occasional breaks from the stress of caring for people with developmental disabilities.

**Supported employment:** Services which provide training, support, and supervision to help applicants to find and keep a job, or to participate in subsistence activities.

**Transportation:** Services to enable applicants to reach work sites and various resources, and to participate in community activities.

**Specialized medical equipment and supplies** which help applicants to experience their surroundings, to communicate, and to perform daily activities.

**Nursing oversight:** Services provided by a registered nurse to ensure that care of a medical nature is delivered in a manner that protects applicant health and safety.

**Intensive active treatment:** Professional treatment/therapy to prevent behavior regression or to address a family, personal, social, mental, behavior, or substance abuse problem.

**Environmental modifications:** Home modifications necessary for applicant health and safety.

**Chore:** Regular cleaning and heavy household chores within a residence where no one else is available.

**Other:**

## ATTACHMENT B

### DDRR standardized criteria

Included information should be provided in full sentence form. Information should be current, and relevant to each section. Descriptive information should be provided so that the reviewer clearly understands the individual's situation. Please note that credit may not be given in multiple sections for a single concern.

#### *Community Participation Concerns*

- 1) *Behavior which causes physical harm to self or others. Injures self (scratches, bites, etc.) or physically assaults others.*
  - a) This section relates to intentional assaultive or self-injurious behaviors. Behaviors considered are those that are outside of the developmental norm for the individual's age and which cause physical harm to self or others.
- 2) *Behavior which interferes with home and/or community life. Frequent, challenging behavior resistant to interventions.*
  - a) This section relates to the impact of an individual's behavior on their ability to engage in their home and community. A description of the behavior's impact on their home and community life should be included. The information provided here should include behaviors in which formal interventions have been tried and been found unsuccessful at mitigating the behavior. Information should be provided regarding what professional level interventions have been tried to address the behavior and why those interventions have been determined ineffective.
- 3) *Behavior leading to justice system involvement. Within the last five years, arrested, charged, jailed, or placed on probation; continues to engage in behaviors likely to result in further involvement in the juvenile or adult justice system.*
  - a) This section refers only to those individuals that have been arrested, charged, jailed or are on probation for a crime. Please provide detail regarding the individual's current behaviors which are likely to lead to further involvement with the criminal justice system. Please provide the date of the most recent contact with the justice system, and the current status of the applicant.
- 4) *Victim of psychological, physical, sexual, and/or financial abuse.*
  - a) The section is for individuals who are victims of definite abuse. Information should demonstrate how the applicant was a victim of abuse.
- 5) *Complex, chronic medical condition. Requires on-going care and frequent attention by medical professionals, and routine supervision regarding medical needs.*
  - a) This section is for individuals who experience a complex and chronic medical condition. Examples of such medical conditions include uncontrollable seizure disorder, serious heart and lung disorders and medical conditions which require life sustaining medical equipment and technologies such as a ventilator.

- 6) *Applicant is caring for children or will be parent within eight months.*
- a) This section should thoroughly describe the circumstances, include names and ages of children, and/or estimated due date:

***Living Situation Concerns***

- 7) *Death of primary caregiver within the past 12 months.*
- a) This section should include the name of caregiver and the date of their death. Information provided should also include the current status of the applicant.
- 8) *No long-term caregiver available to assist with daily care needs.*
- a) Information provided, should include the name of temporary caregiver, their relationship to the applicant and the projected end date of the temporary care. In this section a parent is considered to be the long term caregiver of a minor child. If this is not the case comments should be provided. The Office of Children's Services is also considered to be the long term caregiver for children in their custody and are required to provide the applicant with adequate care.
- 9) *Homeless. No fixed, regular and adequate night-time residence. Spends nights at a supervised shelter providing temporary living, or at a public or private place not intended to be used as a night-time residence for humans; or is facing discharge from an institution within one week, but has no residence or resources to obtain shelter.*
- a) This section is for individuals who are homeless, not those individuals who are staying with friends or family, but do not rent or own their own home. Please provide the last known location of applicant's night time residence and the length of time applicant has been homeless. If applicant is facing discharge from an institution within one week, please provide the date of discharge.
- 10) *Discharge from foster care/Office of Children's Services within a year. Living in foster care, but will be 18 within a year, and is at risk of being homeless because no caregiver has been identified.*
- a) Please provide any additional information as it relates to this section.
- 11) *Current residence is a nursing home, psychiatric treatment facility/hospital or intermediate care facility for the mentally retarded (ICF/MR).*
- a) Please include the name of the treatment facility and the date of admission.
- 12) *Caregiver unable to provide adequate care. Age, health, physical or psychological condition affects ability to continue providing care.*
- a) This section applies to individuals who have an unpaid caregiver, not adults who are capable of providing their own care, or children in foster care who have a paid primary caregiver. Information provided should describe how the caregiver is unable to provide adequate care. Please include information regarding the age, health, physical or psychological condition which impacts the caregiver's ability to continue to provide care.
- 13) *Caregiver unable to meet behavior or health needs of applicant. Supports, skills or training insufficient to meet applicant level of need.*

a) This section should discuss what professional supports have been explored and exhausted as well as any training the caregiver has received to meet the applicant's level of need. Please describe why supports are no longer sufficient to meet the applicant's needs. Please note that grant funds, school services, EPSDT funded support, as well as professional level support should be explored to help the applicant and their family meet their needs.

**14) Caregiver unable to get or hold a job. Needs of applicant interfere with caregiver ability to find or keep employment; resources and options for applicant care during work day have been exhausted.**

a) This section refers to the needs of the applicant being the sole factor preventing the primary unpaid caregiver(s) from working. It does not apply to the probability of the parent(s) losing their job but rather the reality of being unemployed as a result of the applicant's needs.

DRAFT

## Attachment C

### Sample letter with scoring information and confirming placement on the Registry

Date

Dear \_\_\_\_\_,

You are receiving this letter because you recently submitted a Developmental Disabilities Registration and Review (DDRR) form to Senior and Disabilities Services (SDS) on behalf of Applicant's Full Name. SDS is writing to tell you that the form you submitted has been received and scored, and to provide you with additional important information.

The Developmental Disabilities Registry is used to prioritize those seeking services as funds become available. Individuals are selected for services based on their score. Even those with a score of zero may be eligible for services. Applicant's First Name has been placed on the Developmental Disabilities Registry, with a score of \_\_\_\_.

The score is calculated based on your responses to your items on the DDRR. A copy of the form is attached, along with comments by the SDS staff that reviewed and scored the form. Fourteen items are scored. Each of those items has levels of need worth different values. Each item's value was determined by the DDRR Ad Hoc Committee that developed this form. The table attached shows the value of each item.

There are many people on the registry. Highest scores are selected first, and as funding is available. If selected, you will be notified by a certified letter in the mail to the address we have on file.

Once drawn for Home and Community-Based Medicaid Waiver services a person must be eligible for Medicaid. You may visit <http://hss.state.ak.us/dpa/programs/medicaid> for more information on Medicaid eligibility.

To maintain Applicant's First Name's active status on the DD Registry, you will be asked to complete a DDRR form at least every year. You may also complete it any time there is a change in Applicant's First Name's contact information, needs, or life situation. You may download and print the form online at <http://dhss.alaska.gov/dsds/Documents/docs/ddRegAndReview.pdf>, or complete it online at <https://ddregistration.dhss.alaska.gov/>. Please note if you complete the form online, you will need the SDSID number, located on your DD eligibility approval letter.

If you have questions about your DDRR form, or how it was processed, you may contact the IDD Waiver Unit at 1-800-478-9996 or (907) 269-3666.

Sincerely,

Maureen Harwood  
Intellectual and Developmental Disabilities Program Manager  
Intellectual and Developmental Disabilities Program