

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

### APPLICANT INFORMATION

|   |                |         |   |            |
|---|----------------|---------|---|------------|
| Last Name:  | First:         | Middle: | Marital Status (circle one)<br>Single Married Div Sep Widow |            |
| Address:  | City:          | State:  | Zip Code:   | Sex: M / F |
|   | County:        |         |   |            |
| Cell Phone #  | Day/Work #     |         | Home #  |            |
| Email Address:<br>(If applicable)   |                |         |   |            |
| Social Security #:  | Date of Birth: |         | Age:  |            |
| Medical Assistance #:<br>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<br>Hispanic    Other    American Indian/Alaska Native    American Pacific |
| What is the relationship of the person completing this form to the applicant? <input type="checkbox"/> Self <input type="checkbox"/> Parent<br><input type="checkbox"/> Spouse <input type="checkbox"/> Guardian <input type="checkbox"/> Resource/Service Coordinator <input type="checkbox"/> School Counselor <input type="checkbox"/> 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:

|   |  |  |
|---|--|--|
| <b>DDA:</b><br><input type="checkbox"/> Resource/Service Coordination<br><input type="checkbox"/> Day/Supported Employment<br><input type="checkbox"/> CSLA<br><input type="checkbox"/> Supports<br><input type="checkbox"/> Community Pathways or New Directions | <b>MA Waivers:</b><br><input type="checkbox"/> Autism<br><input type="checkbox"/> Model<br><input type="checkbox"/> Traumatic Brain Injury<br><input type="checkbox"/> Living at Home<br><input type="checkbox"/> Older Adults<br><input type="checkbox"/> Medical Day Care<br><input type="checkbox"/> RTC (Residential Treatment Center) | <input type="checkbox"/> REM (Rare & Expensive Case Management)<br><input type="checkbox"/> MA Personal Care<br><input type="checkbox"/> In-Home Aid Services (DSS)<br><input type="checkbox"/> Attendant Care Program |
| <b>OTHERS:</b><br><input type="checkbox"/> Special Education<br><input type="checkbox"/> Division of Rehabilitation Services (DORS)<br><input type="checkbox"/> Food Bank<br><input type="checkbox"/> Transportation  | <input type="checkbox"/> Social Services<br><input type="checkbox"/> Energy Assistance (MEAP)<br><input type="checkbox"/> Housing<br><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<br>(To whom the payment is made) | Cost of Support/Activity/Item | Dates of Support/Activity | Documentation of cost<br>(This must be included) | FOR RESPITE REQUEST ONLY<br><input type="checkbox"/> NAME OF PROVIDER<br><input type="checkbox"/> DAILY RATE<br><input type="checkbox"/> AMOUNT OF DAYS |
|---------------------------------|---|-------------------------------|---------------------------|--|---|
| <b>EXAMPLE:</b><br>-Summer Camp | ABC CAMP<br>123 Any Way<br>Anywhere, MD 12345<br>410-222-2222                                     | \$660.00                      | June 20<br>-<br>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): \_\_\_\_\_