



State of Alaska • Department of Health • Division of Senior and Disabilities Services

Intellectual and Developmental Disabilities Unit

Anchorage Office: Phone: (907) 269-3666; Toll Free: 1-800-770-3930; Fax: (907) 269-3639
550 W. 8th Avenue, Anchorage, AK 99501

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751 Old Richardson Highway, Suite 100-A, Fairbanks, 99701

Developmental Disability Determination Application

Applicants can complete and submit this form, or get help with completing and submitting the form from a DDRC (Developmental Disabilities Resource Connection) agency or an ADRC (Aging and Disability Resource Center). To find a DDRC, visit : https://health.alaska.gov/dsds/Documents/grantservices/PDFs/DDRC\_Roster.pdf or ADRC: https://health.alaska.gov/dsds/Pages/adrc/default.aspx

APPLICANT INFORMATION

Please note – the applicant is the individual for whom the Developmental Disability Determination is being sought.

Last Name First Name M.I.

Address: Street Address Mailing Address (if different)

City: State: Zip:

Telephone Number:

Gender Identification: Male Female Other

Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_
City State

Name of Legal Representative\*:

\*Anyone other than the parent(s) of a minor child MUST include copies of documents that provide evidence of legal authority to act on behalf of the applicant.

Legal Representative's Address:

City: State: Zip:

Home Telephone: Work Telephone:

Cell Telephone: Email:

If someone assisting you with this application should receive a copy of the determination letter, please provide the information below. Please ensure that an Authorization for Release of Information is included for this person. Download Release of Information forms here: https://health.alaska.gov/dsds/Documents/SDSforms/uni/UNI-16-ROI-Form.pdf

Name: Relationship:

Contact:

## **DOCUMENTATION OF FUNCTIONAL LIMITATIONS**

Please include with your application current documentation of substantial functional limitation in at least three of the areas listed below. To assist the determination process, please review your documentation to make sure it is relevant to the determination of developmental disability.

“Substantial functional limitation” means consistently functioning at or near a level that is two standard deviations delayed, or 25% delayed, or functioning at or below the 2nd percentile, compared to the typical functioning of same age peers. Substantial functional limitation must be demonstrated globally in areas of major life activity, as defined in AS 47.80.900 (6) (D). Behavioral reluctance or refusal to perform tasks in an area is not considered a limitation of a person’s ability in an area, but rather, a component in the area of self-direction.

- **All submitted documentation MUST be signed and dated by the professional who administered the assessment or evaluation.**
- **Applicants over the age of 22 must submit evidence that substantial limitations existed prior to age 22.**
- **An application submitted without sufficient supporting documentation of disability will result in a denial of Developmental Disability Determination based on insufficient information.**

Examples of supporting documentation include, but are not limited to:

- a. Developmental assessment by Early Intervention/Infant Learning Program,
- b. School district special education evaluations and evaluation summaries, known in Alaska as the Evaluation Summary & Eligibility Report (ESER),
- c. School district Individual Education Plan (IEP),
- d. Individual Family Service Plan (IFSP),
- e. Neuropsychological assessment,
- f. Psychological assessment,
- g. Evaluations from specialists (e.g., occupational, physical, or speech therapy), and
- h. Division of Vocational Rehabilitation (DVR) assessments and evaluations.

Documentation of the disability prior to age 22 includes, but is not limited to, school records, health records from village clinics, Social Security records, and histories of an applicant’s disability as documented in current evaluations or records.

Please indicate below which attached document(s) and which page number(s) provide an assessment of substantial functional limitation in that specific area.

1. **SELF CARE** - A person’s ability to perform such tasks as eating/drinking, toileting, dressing, and grooming.

- Document Name \_\_\_\_\_ Date \_\_\_\_\_ Pg# \_\_\_\_\_
- Document Name \_\_\_\_\_ Date \_\_\_\_\_ Pg# \_\_\_\_\_
- Document Name \_\_\_\_\_ Date \_\_\_\_\_ Pg# \_\_\_\_\_

2. **EXPRESSIVE & RECEPTIVE LANGUAGE** - A person’s ability to understand the communication of others and to communicate with others through any combination of spoken words, signs, or images that may be printed or electronic.

- Document Name \_\_\_\_\_ Date \_\_\_\_\_ Pg# \_\_\_\_\_
- Document Name \_\_\_\_\_ Date \_\_\_\_\_ Pg# \_\_\_\_\_
- Document Name \_\_\_\_\_ Date \_\_\_\_\_ Pg# \_\_\_\_\_

3. **LEARNING** - A person’s cognitive ability to acquire knowledge or skills through experience, study, or by being taught.

- Document Name \_\_\_\_\_ Date \_\_\_\_\_ Pg# \_\_\_\_\_

➤ Document Name \_\_\_\_\_ Date \_\_\_\_\_ Pg# \_\_\_\_\_

➤ Document Name \_\_\_\_\_ Date \_\_\_\_\_ Pg# \_\_\_\_\_

4. **MOBILITY** - A person’s physical ability to move their body from place to place, control and coordinate gross motor movement.

➤ Document Name \_\_\_\_\_ Date \_\_\_\_\_ Pg# \_\_\_\_\_

➤ Document Name \_\_\_\_\_ Date \_\_\_\_\_ Pg# \_\_\_\_\_

➤ Document Name \_\_\_\_\_ Date \_\_\_\_\_ Pg# \_\_\_\_\_

5. **SELF DIRECTION** - A person’s ability to establish and maintain interpersonal and social relationships, manage emotional responses, display socially appropriate behavior, focus and attend appropriately, use judgment, make decisions, solve problems, plan and execute tasks, and direct behavior toward goals.

➤ Document Name \_\_\_\_\_ Date \_\_\_\_\_ Pg# \_\_\_\_\_

➤ Document Name \_\_\_\_\_ Date \_\_\_\_\_ Pg# \_\_\_\_\_

➤ Document Name \_\_\_\_\_ Date \_\_\_\_\_ Pg# \_\_\_\_\_

6. **CAPACITY FOR INDEPENDENT LIVING** – For age 16+, a person’s ability to maintain a household and access necessary community resources.

➤ Document Name \_\_\_\_\_ Date \_\_\_\_\_ Pg# \_\_\_\_\_

➤ Document Name \_\_\_\_\_ Date \_\_\_\_\_ Pg# \_\_\_\_\_

➤ Document Name \_\_\_\_\_ Date \_\_\_\_\_ Pg# \_\_\_\_\_

7. **CAPACITY FOR ECONOMIC SELF-SUFFICIENCY** – For age 16+ and not enrolled in educational programs, a person’s ability to financially meet their needs such as food, clothing, housing, utilities, and transportation.

➤ Document Name \_\_\_\_\_ Date \_\_\_\_\_ Pg# \_\_\_\_\_

➤ Document Name \_\_\_\_\_ Date \_\_\_\_\_ Pg# \_\_\_\_\_

➤ Document Name \_\_\_\_\_ Date \_\_\_\_\_ Pg# \_\_\_\_\_

**INFORMATION RELEASE AND ASSURANCES**

A separate Authorization for Release of Information must be completed for each agency or individual with whom you wish Senior and Disabilities Services to share information about yourself.

**I certify that the information contained herein is correct and accurate to the best of my knowledge.**

Applicant/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**The Developmental Disability Determination decision will be conveyed in writing to the applicant or the applicant’s legal representative.**

Use the space below if you would like to provide a narrative description to supplement or enhance the required documentation of functional limitations

**STATE USE ONLY**

**INITIAL REVIEW**

Approved/ Date: \_\_\_\_\_  Denied / Date: \_\_\_\_\_  Time Limited/ Date: \_\_\_\_\_

Date Determination Letter Sent:

Health Program Manager Signature:

**RESUBMISSION REVIEW**

Approved/ Date: \_\_\_\_\_  Denied / Date: \_\_\_\_\_  Time Limited/ Date: \_\_\_\_\_

Date Determination Letter Sent:

Health Program Manager Signature:

**MANAGER REVIEW**

Approved/ Date: \_\_\_\_\_  Denied / Date: \_\_\_\_\_  Time Limited/ Date: \_\_\_\_\_

Date Determination Letter Sent:

Unit Manager Signature: