

DDA:

Ten Tips for Navigating the System

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Agenda



- 1) What is DDA
- 2) Why is it important?
- 3) Who can access DDA?
- 4) How does a person become “DDA eligible”?
- 5) What is a waiver?
- 6) How does a person enroll on a waiver?
- 7) What is respite care and how do you get it?
- 8) What is personal care and how do you get it?
- 9) What can you expect from you Case Manager?
- 10) Where do you go for help?

What is the Developmental Disabilities Administration (DDA)?



- ❖ The portion of our **state government**, within DSHS, responsible for providing support and care to people with intellectual and developmental disabilities across their lifespan.
- ❖ Where people with developmental disabilities go to get help for in-home, out-of-home, and community-based services
- ❖ For those who will require long-term services and support, DDA will play a critical role.

Examples of DDA services

Short Term Services

- Overnight Planned Respite (age 18 and older)
- Emergency respite
- Behavior Support Team (Ages 3-17)

Long Term Services

- Personal Care
- Respite Care
- Supported Employment
- Behavior Support
- Supported Living
- Waivers

Other Perks to being a DDA Client

- School to Work
- Housing or Rental Assistance
- Developmental Disabilities Life Enrichment Trust (DDLLOT)
- Parkview Homebuyers Program
- South Mental Health DD Chemical Dependency program



[For a complete list and description of available DDA services](#)

Why is DDA important?

WELCOME TO THE DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)

Supported Employment



**Personal
Care**

- ❖ Long-term care is costly, and most people, even those with financial resources, can't afford to pay for it on their own.
- ❖ Although DDA is not a crisis agency, having them available during an unexpected crisis is a critical safety net.
- ❖ Being DDA eligible enables the state to more accurately count how many people with disabilities live in Washington in order to better prepare and serve them.

Who can access DDA services?

❖ Anyone who has a developmental disability **as defined by Washington State.**

- Not dependent on income
- Exception: Immigration Status

❖ The disability must:

- Have originated before you turned eighteen
- Continue or can be expected to continue indefinitely
- Results in substantial limitations

❖ Your diagnosis must be one of the following:

- Developmental Delays (only until age 9)
- Intellectual Disability
- Cerebral Palsy
- Epilepsy
- Autism (NOT Autism 1)
- Another neurological condition

❖ [A medical diagnosis is not enough.](#)

How do you become DDA eligible?



**The first step to
accessing services from
DDA:**

Become “DDA Eligible”

- ❖ Prove to the state that you meet their definition of developmentally disabled.
- ❖ DDA Eligibility is a yes or no question and is based almost completely on test scores and medical records
- ❖ The application for DDA eligibility takes less than 30 minutes to complete and cannot be done online.

The DDA Application



The Arc
King County

Request for DDA Eligibility Determination (14-151)

Consent (14-012)

Notice of Privacy Practices for Client Confidential Information (03-387)

Washington State Voter Registration for applicants age 18 or older

DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)
Request for DDA Eligibility Determination

FOR OFFICE USE ONLY
 Initial Reapplication
DDA NUMBER: _____

Applicant Information
FIRST NAME: _____ MIDDLE INITIAL: _____ LAST NAME: _____ BIRTHDATE: _____

GENDER
 Female Male Unknown / Unreported

MARITAL STATUS
 Never Married Married Separated Widowed Unmarried Partner Unknown

APPLICANT'S COMMUNICATION NEEDS
Interpreter Required: Yes No
Sight English: Yes No
Hear English: Yes No
Translate Documents: Yes No
Understands English: Yes No
Primary spoken language: _____
Other describe: _____

TRIBAL ENROLLMENT
 Yes No

SOCIAL SECURITY NUMBER

HIGHEST EDUCATION LEVEL OR TYPE

ETHNIC CODES (CHECK ALL THAT APPLY)
 American or Alaska Native Black or African American Asian Native Hawaiian / Other Pacific Islander White Unreported

MEDICARE
Yes: type: Adult-Licensed Facility Homeless Relative's home
 No Child - foster home Hospital, medical Own Home
Other insurance: Correctional Facility / Jail Hospital, psychiatric Parent's Home
 Nursing Facility Other describe: _____

STREET ADDRESS _____ **CITY** _____ **STATE** _____ **ZIP CODE** _____ **COUNTY OF RESIDENCE** _____

WASHINGTON IS MILITARY HOME OF RECORD
 Yes No

MAILING ADDRESS (IF DIFFERENT) _____ **CITY** _____ **STATE** _____ **ZIP CODE** _____

PRIMARY PHONE NUMBER CELL HOME WORK OTHER PHONE NUMBER CELL HOME WORK MESSAGE EMAIL ADDRESS _____

LIBRARY SCHOOL DISTRICTS ATTENDED AND DATES

TELL US WHY YOU ARE APPLYING

DEVELOPMENTAL DISABILITY AND THE AGE FIRST OBSERVED
Age first diagnosed: _____
 Autism Epilepsy Intellectual Disability Mental health Neurological Condition Chromosomal Condition Neurological Condition Developmental Delay

DISABILITY DETERMINATION SERVICE APPLICATION
Has the applicant applied for Social Security Disability Benefits, Supplemental Security Income, or DSHS Non-Grant Medical Assistance in the last year?
 Yes No

Representative Information
FIRST NAME: _____ MIDDLE INITIAL: _____ LAST NAME: _____ PRIMARY LANGUAGE: _____
MAILING ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____
Interpreter: Yes No
Translation: Yes No
RELATIONSHIP TYPE / ROLE: _____ LEGAL RELATIONSHIP (ATTACH DOCUMENTS): _____ LIVES WITH APPLICANT: Yes No
NAME OF OTHER PARTY: _____
Signature(s)
SIGNATURE OF ADULT APPLICANT: _____ DATE: _____
SIGNATURE OF PARENT OR LEGAL REPRESENTATIVE: _____ DATE: _____ LEGAL RELATIONSHIP: _____

REQUEST FOR DDA ELIGIBILITY DETERMINATION
DDHS 14-151 (REV. 04/2015)

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Consent

NOTICE TO CLIENTS: The Department of Social and Health Services (DSHS) can help you better if we are able to work with other agencies and professionals that know you and your family. By signing this form, you are giving permission for DSHS and the agencies and individuals listed below to use and share confidential information about you. DSHS cannot release you benefits if you do not sign this form unless your consent is needed to determine your eligibility. If you do not sign this form, DSHS may still share information about you to the extent allowed by law. If you have questions about how DSHS shares client confidential information or your privacy rights, please consult the DSHS Notice of Privacy Practices or ask the person giving you this form.

CLIENT IDENTIFICATION:
Name: _____ DATE OF BIRTH: _____ IDENTIFICATION NUMBER: _____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____
TELEPHONE NUMBER (INCLUDE AREA CODE): _____ OTHER INFORMATION: _____

CONSENT:
I consent to the use of confidential information about me within DSHS to plan, provide, and coordinate services, treatment, payments, and benefits for me or for other purposes authorized by law. I further grant permission to DSHS and the below listed agencies, providers, or persons to use my confidential information and disclose it to each other for these purposes. Information may be shared verbally or by computer, data transfer, mail, or hand delivery.
Please check all below who are included in this consent in addition to DSHS and identify them by name and address:
 Health care providers
 Mental health care providers
 Substance use disorder service providers
 Housing programs
 School districts or colleges
 Department of Corrections
 Employment Security Department and its employment partners
 Social Security Administration or other federal agency
 See attached list
 Other: _____

I authorize and consent to sharing the following records and information (check all that apply):
 All my client records Records on attached list
 Only the following records: _____
 Family, social and employment history Health care information Treatment and care plans
 Payment records Individual information School, education, and training
 Other (list): _____

PLEASE NOTE: If your client records include any of the following information, you must also complete this section to include these records.
 Mental health HIV/AIDS and STD test results, diagnosis, or treatment Substance Use Disorder (date or event)
- This consent is valid for one year as long as DSHS needs records, or until _____ (date or event).
- I may revoke or withdraw this consent at any time in writing, but that will not affect any information already shared.
- I understand that records shared under this consent may no longer be protected under the laws that apply to DSHS.
- A copy of this form is valid to give my permission to share records.

SIGNATURE: _____ DATE: _____ WITNESS (NOTARY SIGN AND PRINT NAME, IF APPLICABLE): _____ DATE: _____
PARENT OR OTHER REPRESENTATIVE'S SIGNATURE (IF APPLICABLE): _____ TELEPHONE NUMBER (INCLUDE AREA CODE): _____ DATE: _____

If I am not the subject of the records, I am authorized to sign because I am the: (attach proof of authority)
 Parent Legal Guardian (attach court order) Personal representative Other

NOTICE TO SERVICES PROVIDERS AND CONTRACTORS: If these records contain information about HIV, STDs, or AIDS, you may not further disclose that information without the client's specific permission. If you have received information related to drug or alcohol abuse by the client, you must include the following statement when further disclosing information as required by 42 CFR 2.32:
This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to commonly investigate or prosecute any alcohol or drug abuse patient.

CONSENT
DDHS 14-012 (REV. 04/2015)

DSHS NOTICE OF PRIVACY PRACTICES FOR CONFIDENTIAL INFORMATION
Effective September 23, 2013

Acknowledgement
(Needed when DSHS provides direct health care treatment)

CLIENT NAME: _____ CLIENT DATE OF BIRTH: _____

I have received a copy of the DSHS Privacy Notice and have had a chance to ask questions about how DSHS will use and share my Personal Health Information.

CLIENT OR PERSONAL REPRESENTATIVE SIGNATURE: _____ DATE: _____

FOR DSHS USE ONLY
To be completed if unable to obtain signature of client or personal representative.

Describe efforts made to have the client acknowledge receipt of the Notice of Privacy Practices (NPP):

Describe reason why acknowledgement was not obtained:

STAFF MEMBER'S NAME AND TITLE (PLEASE PRINT): _____ ADMINISTRATION/DIVISION: _____
STAFF'S SIGNATURE: _____ DATE: _____

DDHS 03-387 (REV. 06/2015)

Instructions
Use this form to register to vote or update your current registration.

Print all information clearly using black or blue pen. Mail this completed form to your county elections office (address on back).

Deadline
This registration will be in effect for the next election if received by the elections office no later than eight days before Election Day.

Voting
You will receive your ballot in the mail. Contact your county elections office for accessible voting options.

Public Benefits Offices
Your name, address, gender, and date of birth will be public information if you are at least eighteen years of age.

Notice
Knowingly providing false information about yourself or your qualifications for voter registration is a class C felony punishable by imprisonment for up to five years, a fine of up to \$10,000, or both.

Public Benefits Offices
If you received this form from a public benefits office, where you received the form will remain confidential and will be used for voter registration purposes only.

Registering or declining to register will not affect the assistance provided to you by any public benefits office. If you decline to register, your decision will remain confidential.

If you believe someone interfered with your right to register or your right to privacy in deciding whether to register, you may file a complaint with the Washington State Elections Division.

Contact Information
If you would like help with this form, contact the Washington State Elections Division.
web: www.wctov.gov
call: (800) 448-4881
email: elections@wa.wa.gov
mail: PO Box 40229 Olympia, WA 98504-0229

Washington State Voter Registration Form
Registration at: www.wctov.gov

1 Personal Information
last first middle suffix
date of birth (mm/dd/yyyy) gender
residential address in Washington apt #
city ZIP
mailing address, if different
city state and ZIP
phone number (optional) email address (optional)

2 Qualifications
If you answer no, do not complete this form.
 Yes No I am a citizen of the United States of America.
 Yes No I am at least eighteen years old, or at least sixteen years old and will vote only after turn eighteen.

3 Military / Overseas Status
 Yes No I am currently serving in the military. Includes National Guard and Reserve and spouses or dependents away from home due to service.
 Yes No I live outside the United States.

4 Identification - Washington Driver License, Permit, or ID
If you do not have a Washington driver license, permit, or ID, you may use the last four digits of your Social Security number to register.
X X X X - X X X X

5 Change of Name or Address
This information will be used to update your current registration, if applicable.
former last name first middle
former residential address city state and ZIP

6 Declaration
I declare that the facts on this voter registration form are true. I am a citizen of the United States. I will have lived at this address in Washington for at least thirty days immediately before the next election at which I vote. I will be at least eighteen years old when I vote. I am not disqualified from voting due to a court order, and I am not under Department of Corrections supervision for a Washington felony conviction.
sign here date here

What is a Waiver?

Becoming DDA eligible provides you with few direct services. In order to access certain resources, including respite care, personal care and employment support, you must also be enrolled on a waiver.

- ❖ A waiver is a package of services that increase in levels of support and services, depending on the individual's level of need.
- ❖ You must use (or try to use) the services they give you and show that it isn't enough help before they'll give you more.
- ❖ When enrolled on a waiver you become eligible for Medicaid, regardless of income. Medicaid can be used as a secondary insurance, and to access personal care.

Why is it called a Waiver?

It is an agreement to *wave* the option to receive services in an institutional setting and choosing instead to receive the same or similar services in their own home and community.

How do you enroll on a Waiver?

- ❖ “I’d like to request a needs assessment in order to be enrolled on a waiver.”
 - To request a needs assessment:
R2ServiceRequestB@dshs.wa.gov or 1-800-974-4428
 - Expect a response in 1-2 weeks
- ❖ Needs assessment: *TIME TO GET REAL*
- ❖ Most waivers are at capacity so likely you will be denied initially. Work with your case manager to decide when it’s the right time to reapply.
- ❖ When requesting a waiver, be sure to explain exactly why you need that waiver and why the other services you currently receive are not adequate.

Waivers are awarded based on urgency of need, not first come first serve, and there is no waitlist. Keep in very close contact with DDA, notifying them of anything new or different including:

- Increase in challenging behaviors
- New diagnosis or medical condition
- New care/support needs
- Pictures and videos are your friends

What is respite care?

Purpose: To allow the primary caregiver a break so that they can continue being the primary care giver, preventing out of home placement.

- ❖ Short-term, intermittent relief for parents/caregivers, where the person with a disability receives care from another person so that the main caregiver can take a break.
- ❖ Respite care is NOT “Child Care” while the parent is at work.
- ❖ The many forms of Respite Care:
 - One-on-One care in your home or the local community for a few hours at a time
 - After-school care, camps, adult day centers, specialized classes, etc. offered by a DDA contracted organization
 - Overnights, weekends, or longer care at a friend/relative’s house or licensed facility

What is personal care?

Purpose: To provide DIRECT assistance to a person with disabilities with their Activities of Daily Living (ADLs)

What a Personal Care Provider CAN do:

Bathing	Dressing
Toilet Use	Eating
Meal Prep	Essential Shopping
Telephone Use	Personal Hygiene
Bed Mobility	Travel to Medical
Transfer	Ordinary Housework
Wood Supply	Locomotion
Body Care	Meds Management

- ❖ Can't provide childcare, supervision, or skilled nursing
- ❖ Can be provided in the client's home, an Adult Family Home, Assisted Living Facility, or Nursing Home. It can also be provided in the community if it meets the client's care needs.
- ❖ Only parents of clients 18 and over can become paid caregivers.

What to expect from your DDA Case Resource Manager (CRM)



- ❖ CRMs hold caseloads of ~75 people.
- ❖ You have the right to call or email any time. Allow 48 hours for a response. Don't expect the CRM to reach out to you except for the annual assessment. Therefore, if you are having challenges, need more services, or have questions, you must be the one to seek help.
- ❖ If you do not hear back from your CRM or are concerned about their work, contact their supervisor.
 - You can find out who the supervisor is by calling the DDA front desk at **206-568-5700**
- ❖ CRMs should know about the DDA services available to you. They have limited knowledge about non-DDA services.

Where do you go with concerns?

CRMs are doing their best, but DDA is a complicated and ever-changing system so it is easy to make mistakes. If you suspect the information you receive is inaccurate or you are turned down for services, you have a few options:

- ❖ Ask for clarification from the CRM
- ❖ Talk to their supervisor
- ❖ Work your way up the supervisory chain
- ❖ Contact The Arc of King County





Contact Us

The Arc of King County

Information and Family Support

English: 206-829-7053 OR Ask@arcofkingcounty.org

Spanish: 206-829-7030 OR Preguntas@arcofkingcounty.org

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